Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Director's Office
www.dcbs.oregon.gov

August 31, 2017

The Honorable Thomas E. Price, M.D.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Price,

Oregon has seen significant improvements under the Affordable Care Act (ACA). The state's uninsured rate has been reduced from 17 percent to just 5 percent, and more individuals are able to purchase and afford coverage. The individual market has grown significantly, from 167,000 in 2013 to 218,000 in 2018. These coverage gains have saved Oregon's health system approximately $500 million in uncompensated hospital care per year since 2013.

Even with these improvements, Oregon's traditionally competitive individual health insurance market has undergone an unprecedented amount of change. Seven insurers, including the state's two consumer operated and oriented plans (CO-OPs), have ceased to do business in the individual market. Also, remaining insurers have shrunk their geographic footprint and have significantly increased premiums.

Despite these carrier withdrawals, most Oregonians will have multiple health carriers to choose from both on and off the exchange, and all counties will have at least one on-exchange carrier in 2018.

It is important that the State of Oregon take action to stabilize the individual health insurance market before further change leads to one or more counties with no on-exchange carrier options. Therefore, the State of Oregon, through its Department of Consumer and Business Services (DCBS), is submitting for your review and consideration a Section 1332 State Innovation Waiver application.

We request that Section 1312(c)(1) under Section 1332 of the ACA be waived for a period of five years beginning in the 2018 plan year to develop a state reinsurance program. This waiver will not affect any other provision of the ACA. It will result in a lower marketwide index rate and will reduce premiums and federal payments of advance premium tax credits (APTC). In order to partially fund the Oregon Reinsurance Program, Oregon seeks federal pass-through funds, provided by APTC savings, that are estimated to be in excess of $30 million per year through 2027.

DCBS estimates that the Oregon Reinsurance Program will result in a net premium decrease of 7.1 percent in 2018 and 6.5 percent in 2019. The program is also expected to encourage insurers to maintain and possibly expand geographic coverage areas.

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Thank you for your consideration of our waiver request. If there are any questions we can answer or more information we can provide during the review of Oregon's application, please contact me at Jean.M.Straight@oregon.gov or at 503-947-7872.

Sincerely,

Jean Straight
Acting Director
Oregon Department of Consumer and Business Services

Oregon 1332 Draft Waiver Application

August 31, 2017

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Executive Overview

Request

The State of Oregon, through its Department of Consumer and Business Services (DCBS), submits this 1332 State Innovation Waiver request to the United States Department of the Treasury and to the Centers for Medicare and Medicaid Services (CMS), a division of the United States Department of Health and Human Services (HHS). This request seeks waiver of Section 1312(c)(1) under Section 1332 of the Affordable Care Act (ACA) for a period of five years beginning in the 2018 plan year to develop a state reinsurance program. This waiver will not affect any other provision of the ACA, but will result in a lower marketwide index rate, thereby lowering premiums and reducing federal payment of advance premium tax credits (APTC).

Basis for Request and Goal of Reinsurance Program

During the past few years, Oregon's individual health insurance market has undergone an unprecedented amount of change. Several insurers have withdrawn from the state or shrunk their geographic footprint, premiums have increased significantly, and plans have narrower networks. Two insurers – both consumer operated and oriented plans (CO-OPs) – ceased operations.

The creation of a state reinsurance program through a 1332 waiver will bring certainty and stability to Oregon's individual health insurance market. By reimbursing insurers for high-cost claims, the reinsurance program will spread risk across the broader Oregon health insurance market, thereby lowering premiums. The program is also expected to encourage insurers to maintain and possibly expand geographic coverage areas.

Operation, Funding, and Impact of the Oregon Reinsurance Program (ORP)

House Bill 2391, signed into law on July 5, 2017, establishes the Oregon Reinsurance Program to be administered by DCBS. Total funding for the ORP for 2018 is estimated to be approximately $90 million. The ORP will be funded through a 0.3 percent premium assessment levied on major medical premiums for policies issued in this state and through excess fund balances currently held in two state programs.[1] HB 2391 makes this funding contingent on granting of this waiver request. Through this waiver request, Oregon seeks federal pass-through funds – provided via net premium tax credit savings, estimated to be in excess of $30 million per year through 2027 – to partially recoup state expenditures.

The ORP will operate like a traditional reinsurance program by reimbursing qualifying individual health insurers for a percentage of an enrollee's claims between an attachment point and a cap. In 2018, the ORP will likely reimburse 50 percent of claims between the attachment point and an estimated $1 million cap. DCBS will set the program parameters

[1] The ORP will be funded by 20 percent of the 1.5 percent assessment described in Section 5 of HB 2391.

through administrative rule. DCBS estimates that the ORP will result in a net premium decrease of 7.5 percent in 2018 and 7.0 percent in 2019.

Compliance with Section 1332

Waiver of Section 1312(c)(1) will not impact the comprehensiveness of coverage in the Oregon insurance markets. As noted above, the waiver will reduce premiums and increase affordability. As a result, DCBS estimates enrollment in the individual market will increase by approximately 1.7 percent in 2018, 1.6 percent in 2019, and 1.4 percent in the eight years remaining in the 10-year budget cycle (see Table 1, which follows). Due to the resulting reduction in individual health insurance premiums, including premiums for the second-lowest-cost silver plan, the federal government will see a net reduction in spending of more than $30 million for each year the five-year waiver and ORP are in place.

Table 1[2]

Scenario	1	2 – Best Estimate	3	4	5	6
Enrollment	Constant	Reactive	High	Constant	Reactive	High
Premiums	Rate Filings	Rate Filings	Rate Filings	Low	Low	Low
Baseline						
Total Non-Group Enrollment	207,060	200,793	212,997	207,060	200,793	212,997
Exchange Enrollment	126,881	125,032	132,818	126,881	125,032	132,818
APTC Enrollment	93,322	93,322	100,539	93,322	93,322	100,539
Total Non-Group Premium PMPM	$507.57	$507.57	$507.57	$483.40	$483.40	$483.40
Exchange Premium PMPM	$537.87	$537.87	$537.87	$512.26	$512.26	$512.26
APTC PMPM	$424.68	$424.68	$424.68	$404.46	$404.46	$404.46
Total Non-Group Premiums	$1,261,165,673	$1,222,995,400	$1,297,329,549	$1,201,110,165	$1,164,757,524	$1,235,551,951
Total APTCs	$475,581,251	$475,581,251	$512,360,158	$452,934,524	$452,934,524	$487,962,055
After Reinsurance						
Reinsurance Funding	$90,000,000	$90,000,000	$90,000,000	$90,000,000	$90,000,000	$90,000,000
Reduction in Premiums (Reinsurance Funding)	-7.1%	-7.4%	-6.9%	-7.5%	-7.7%	-7.3%
Reinsurance Assessment	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Reduction in Premiums (Improved Morbidity)	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%
Total Premium Impact	-7.2%	-7.5%	-7.0%	-7.6%	-7.9%	-7.4%
Total Non-Group Premium PMPM	$470.79	$469.65	$471.93	$446.55	$445.40	$447.69
Exchange Premium PMPM	$498.90	$497.68	$500.11	$473.21	$472.00	$474.42
APTC PMPM	$393.90	$392.95	$394.86	$373.62	$372.66	$374.58
Percent Change in Total Enrollment	1.7%	1.7%	1.6%	1.8%	1.8%	1.6%
Total Non-Group Enrollment	210,513	204,162	216,300	210,702	204,346	216,480
Exchange Enrollment	127,900	126,026	133,766	127,955	126,080	133,818
APTC Enrollment	93,322	93,322	100,539	93,322	93,322	100,539
Total Premiums	$1,189,286,565	$1,150,603,237	$1,224,941,794	$1,129,059,223	$1,092,196,949	$1,162,988,100
Total APTCs	$441,119,306	$440,047,877	$476,385,661	$418,404,959	$417,333,784	$451,914,390
Savings						
Estimated APTC Savings	$34,461,945	$35,533,373	$35,974,498	$34,529,566	$35,600,740	$36,047,665
Estimated Net Federal Savings	$31,816,345	$32,866,704	$33,312,665	$31,857,135	$32,907,853	$33,359,779

[2] Oregon expects to revisit its assumptions and consult with stakeholders annually for all waiver years as outlined in the approval of Alaska's 1332 waiver request.

I. Oregon 1332 Waiver Request

Oregon's individual health insurance market, like others across the country, has been through significant changes and challenges in the past few years. Even though the number of insurers participating has decreased, Oregon's health insurance market continues to be relatively competitive and stable. This is largely due to the state's efforts to work collaboratively with Oregon's health insurers to ensure a stable and adequately priced market with multiple plan options throughout the majority of the state.

Oregon seeks waiver of Section 1312(c)(1) under Section 1332 of the ACA for a five-year period beginning in the 2018 plan year to develop a state reinsurance program. The ORP is intended to further stabilize the individual market, reduce rates, and to encourage insurance companies to offer plans in more parts of the state.

Section 1312(c)(1) requires "all enrollees in all health plans … offered by [an] issuer in the individual market … to be members of a single risk pool." Waiver of the single risk pool requirement, to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market wide index rate, will not affect any other provision of the ACA.[3] Consideration of these payments will lower the marketwide index rate. A lower index rate will lower premiums for Oregon's second lowest-cost silver plan, which will reduce the overall APTC that the federal government is obligated to pay for Oregon subsidy-eligible consumers.

Without a reinsurance program, individual health insurance premiums will continue to rise at an unsustainable rate. Consequently, more Oregonians will choose or be forced to go without health insurance, further driving up rates due to adverse selection and provider cost shifting. By implementing a reinsurance program, Oregon will reduce the potential for further market disruption, lower the cost of individual premiums, and decrease federal government APTC obligations.

Table 1 shows that, after factoring in the waiver and the ORP, average 2018 federal APTC payments are estimated to be $392.95 per member per month. Table 1 also shows that without the waiver and the ORP, 2018 federal APTC payments will be an estimated $31.73 per member per month higher. As Table 2 shows, even with a 1.7 percent increase in individual market enrollment, 2018 federal APTC obligations are still estimated to decrease by nearly $33 million. Similar savings are estimated for the remainder of the 10-year budget cycle.

[3] Oregon has already implemented all requirements of the ACA – many of which are incorporated into state law – and is committed to the continued enforcement of the ACA.

Table 2

Best Estimate Assumptions	
Enrollment	Reactive
Premiums	Rate Filings
Total Reduction in Premiums	-7.5%
Estimated Net Federal Savings	$32,866,704

To establish the state's reinsurance program, Oregon seeks federal pass-through funds in the amount the federal government would have otherwise paid in APTC absent consideration of the reinsurance payments in the marketwide index rate. By mitigating high-cost individual health insurance claims, the ORP will help to stabilize Oregon's individual market and make premiums more affordable. With the waiver and reinsurance program, Oregon anticipates that individual premiums, including premiums for the second-lowest-cost silver plan, will be lower, net of the premium assessment, by 7.5 percent in 2018, 7.0 percent in 2019, and 6.4 percent in 2020 through 2027 than they would have been without the waiver and reinsurance program.[4]

II. Compliance with Section 1332 Guardrails

A. Comprehensive Coverage Requirement (1332(b)(1)(A)):

Neither a waiver of Section 1312(c)(1) nor the ORP will affect covered benefits for Oregonians. Regardless of whether the waiver is granted, all Oregon ACA-compliant plans will be required to provide coverage of essential health benefits. Similarly, the scope of benefits provided by other types of coverage such as Medicaid, CHIP, and grandfathered plans will not be impacted.

B. Affordability Requirement (1332(b)(1)(B)):

As stated in Section I, waiver of Section 1312(c)(1), together with the ORP, will make the cost of individual coverage lower each year than it would be without the waiver. The waiver will not affect cost sharing or the affordability of minimum essential coverage obtained through other means, such as Medicaid, CHIP, employer based insurance, or other types of coverage, and the same number of people will have access to such coverage as they would without the waiver.[5] Although employer health plans will have a 0.3 percent assessment to fund the ORP, employer contributions and employee wages are not expected to be affected by the waiver. The waiver will have a positive effect on vulnerable people who buy coverage in the individual market since premiums will be lower.

[4] The final approved 2018 rates were determined independently and reflect all new taxes, including those not applicable to the ORP. The results of the 1332 waiver analysis are consistent with the results of rate review through June 30, 2017.

[5] It's estimated that 3,000 more individuals will obtain individual health insurance in 2018.

C. The Scope of Coverage Requirement (1332(b)(1)(C)):

As previously noted, waiver of Section 1312(c)(1), together with the ORP, will reduce the cost of coverage in the individual market. In each year of the waiver, the lower cost of coverage will allow more Oregonians to purchase or maintain coverage in the individual market than without the waiver. As indicated in Table 2 on page 4 of Attachment 1, enrollment is expected to increase by approximately 1.7 percent in 2018 and thereafter, essentially remaining constant through 2027. Those who obtain minimum essential coverage through other means, such as Medicaid, CHIP, employer-based insurance, or other types of coverage, will have the same access to coverage as they would without the waiver. The waiver will have a positive effect on vulnerable people who buy coverage in the individual market since premiums will be lower.

D. The Federal Deficit Requirement (1332(b)(1)(D)):

As stated above, with the waiver and reinsurance program, Oregon anticipates that individual premiums, including premiums for the second-lowest-cost silver plan, will be lower, net of the premium assessment, by 7.5 percent in 2018, 7.0 percent in 2019, and 6.4 percent in 2020 through 2027 than they would have been without the waiver and reinsurance program. Because APTC are tied to the second-lowest-cost silver plan, these lower premiums, the federal government will pay less in APTC. As Table 3, which follows, demonstrates, the federal government will save more than $356 million over this 10-year budget cycle.

Table 3

Category of Impact	Impact to Federal Deficit Savings/Costs
Difference in APTCs	$385.6 million
Difference in Individual Shared Responsibility Payment	-$4.3 million
Difference in Exchange User Fees	-$11.8 million
Difference in Health Insurance Providers Fee	-$12.9 million
Total Savings over 10-Year Window	$356.6 million

III. Description of the Oregon 1332 Waiver Proposal

A. House Bill 2391[6]

HB 2391, which establishes the ORP within DCBS and gives DCBS the authority to implement a 1332 waiver, was signed into law by Oregon Gov. Kate Brown on July 5, 2017. On of the goals of HB 2391 is to stabilize rates and premiums for individual major medical health insurance plans and provide greater financial certainty to health insurers and health insurance consumers.

[6] A copy of HB 2391 is included with this waiver request and is marked as Attachment 2.

HB 2391 creates a 1.5 percent assessment on fully insured commercial major medical premiums, including premiums for self-insured public plans, for eight calendar quarters beginning at plan renewal on or after Jan. 1, 2018. Commercial market insurers subject to the assessment are permitted to raise member premiums by 1.5 percent.

The amount of the 1.5 percent assessment that will go toward funding the ORP will be phased in over the 10-year budget cycle. The amount of the assessment that is anticipated to go to funding the ORP will be 0.3 percentage points in 2018, 0.6 percentage points in 2019, and the full 1.5 percent assessment in 2020. In 2018, the balance of two existing funds – the Oregon Health Insurance Marketplace (OHIM) fund in excess of six-months' operating budget and the Oregon Medical Insurance Pool (OMIP) account balance – will also be used to fund the ORP. Together, these funding sources are expected to provide approximately $90 million for the ORP in 2018. Ultimately, the ORP's funding is contingent on the granting of this waiver request and the receipt of federal pass-through funds.

HB 2391 requires that DCBS establish reinsurance program requirements, including the reinsurance program attachment point, co-insurance rate, reinsurance cap, and payment processes, by administrative rule. The bill also gives DCBS the authority to apply for a federal waiver to carry out the reinsurance program.

B. The ORP and Federal Pass-Through Funding

The ORP is designed to improve Oregonians' access to affordable and comprehensive coverage. The goals of the reinsurance program are to spread the risk of high-cost claimants across the broader health insurance market, thereby lowering premiums for the individual market. In doing so, the reinsurance program should incentivize individual enrollees to join or remain in the market, encourage insurer participation, and reduce overall instability. In addition to providing lower premiums to Oregonians, the reinsurance program will also reduce federal expenditures through lower APTC.

Because the amount of APTC available for eligible consumers is tied to the second-lowest-cost silver plan available through the Oregon Health Insurance Marketplace (OHIM), the amount the federal government will be required to pay in APTC will be reduced. Through this waiver request, Oregon seeks the amount of federal savings from these reduced APTC payments, net of other costs that result from the waiver and the ORP. Oregon seeks these funds to offset some of the costs associated with the reinsurance program.

The ORP will reimburse individual health insurers for a proportion (co-insurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2018, Oregon is likely to set the reinsurance cap at $1 million, the co-insurance rate at 50 percent, and the attachment point at an amount so that total estimated reinsurance payments

match the funding available. If the 2018 experience is worse than expected and the funding is not sufficient, DCBS will reduce the coinsurance rate and decrease reinsurance payments. If the 2018 experience is better than expected, Oregon will retain the funds in reserve for future payouts.

IV. Draft Waiver Implementation Timeline

DCBS will implement the ORP through its Division of Financial Regulation (DFR). DFR will promulgate the ORP's operating processes, requirements, payment parameters, and procedures through administrative rules.[7] The ORP will collect program funds from assessments on insurers, collect and analyze reinsurance claims, and distribute reinsurance payments to eligible insurers. Oregon has a number of initiatives designed to incentivize providers, payers, and enrollees to contain and manage health care costs and use for high-claims-cost individuals. The ORP is not anticipated to include additional incentives.

07/05/17: The ORP is signed into law.
07/25/17: The public comment period begins.
08/24/17: The first public comment hearing is held.
08/25/17: The second public comment hearing is held.
08/25/17: Separate tribal consultation occurs.
08/26/17: The public comment period ends.
08/31/17: The 1332 waiver application is submitted to the federal government.
09/08/17: The federal government determines that the waiver application is complete.
10/06/17: Relevant parts of HB 2391 become operational and bill becomes effective.
10/09/17: DCBS staffs the ORP.
11/30/17: OHIM's excess funds are transferred to ORP.
11/30/17: OMIP's fund balance is transferred to ORP.
01/01/18: The federal government grants 1332 waiver and funds the ORP for 2018.
05/15/18: Insurers pay first quarterly assessment (2018) to fund the ORP.
06/01/18: Administrative rules for the ORP are issued.
06/22/18: DCBS holds six-month public forum required by 45 CFR 155.1320(c).
08/15/18: Insurers pay second quarterly assessment (2018) to fund the ORP.
12/15/18: Insurers pay third quarterly assessment (2018) to fund the ORP.
01/01/19: The federal government funds the ORP for 2019.
02/01/19: Insurers submit fourth quarter 2018 claims to the ORP.
03/15/19: Insurers pay fourth quarterly (2018) assessment to fund the ORP.
04/01/19: DCBS submits first annual report to the federal government.
04/30/19: DCBS submits its first quarterly report to the federal government.

[7] At the time of drafting this request, administrative rules had not yet been written.

05/15/19: Insurers pay first quarterly assessment (2019) to fund the ORP.
06/21/19: DCBS holds annual public forum required by 45 CFR 155.1320(c).
07/31/19: DCBS submits its second quarterly report to the federal government.
08/15/19: Insurers pay second quarterly assessment (2019) to fund the ORP.
10/01/19: Insurers submit 2018 claims to the ORP.
10/31/19: DCBS submits its third quarterly report to the federal government.
12/15/19: Insurers pay third quarterly assessment (2019) to fund the ORP.
12/31/19: The ORP reimburses insurers for 2018 eligible claims.
01/01/20: The federal government funds the ORP for 2020.
01/31/20: DCBS submits fourth quarterly report to the federal government.
02/01/20: Insurers submit fourth quarter 2019 claims to the ORP.
03/15/20: Insurers pay fourth quarterly (2019) assessment to fund the ORP.
02/28/20: DCBS submits its fourth quarterly report to the federal government.
04/01/20: DCBS submits its second annual report to the federal government.
04/30/20: DCBS submits its first quarterly report to the federal government.
05/15/20: Insurers pay first quarterly assessment (2020) to fund the ORP.
06/21/20: DCBS holds annual public forum required by 45 CFR 155.1320(c).
07/31/20: DCBS submits its second quarterly report to the federal government.
08/15/20: Insurers pay second quarterly assessment (2020) to fund the ORP.
10/01/20: Insurers submit 2019 claims to the ORP.
10/31/20: DCBS submits its third quarterly report to the federal government.
12/15/20: Insurers pay third quarterly assessment (2020) to fund the ORP.
12/31/20: The ORP reimburses insurers for 2019 eligible claims.[8]

V. Additional Information and Reporting

A. Administrative Burden

Waiver of Section 1312(c) will cause minimal administrative burden and expense for Oregon and for the federal government. The waiver will cause no additional administrative burden to employers and individual consumers because Section 1312(c) does not relate to the administrative functions or requirements typically undertaken by employers or individuals. Individual health insurers also will see no additional administrative burden.[9]

Oregon has the resources and staff necessary to absorb the following administrative tasks that the waiver will require the state to perform:

[8] The timing of these activities continues substantially as above through 2022, at which time Oregon may seek to renew its waiver.
[9] Individual health insurers will experience additional administrative burden and associated expense as a result of the ORP; however, the waiver itself will result in no additional administrative burden or cost, and the monetary benefit from the ORP will far exceed any resulting administrative expense.

- Administer the ORP
- Distribute federal pass-through funds
- Monitor compliance with federal law
- Collect and analyze data related to the waiver
- Perform reviews of the implementation of the waiver
- Hold annual public forums to solicit comments on the progress of the waiver
- Submit annual reports (and quarterly reports, if ultimately required) to the federal government

The waiver will require the federal government to perform the following administrative tasks:

- Review documented complaints, if any, related to the waiver.
- Review state reports.
- Periodically evaluate the state's 1332 waiver program.
- Calculate and facilitate the transfer of pass-through funds to the state.

Oregon believes that the above administrative tasks are similar to other administrative functions currently performed by the federal government, so that their effect is insignificant. Waiver of Section 1312(c)(1) does not necessitate any changes to the Federally-Facilitated Marketplace and will not affect how APTC or cost-sharing reduction payments are calculated or paid.

B. Impact on Residents Who Need to Obtain Health Care Services Out-of-State

Because Oregon shares borders with Washington, Idaho, Nevada, and California, insurer service areas and networks that cover border counties generally contain providers in those states, especially in areas where the closest large hospital system is located in the border state. Granting this waiver request will not affect insurer networks or service areas that provide coverage for services performed by out-of-state providers.

C. Ensuring Compliance, Waste, Fraud and Abuse

DFR is responsible for regulating and ensuring regulatory compliance and monitoring the solvency of all issuers; performing market conduct analysis, examinations, and investigations; and providing consumer outreach and protection. DFR investigates all complaints that fall within the division's regulatory authority.

The State of Oregon and DCBS annually prepare comprehensive financial accounting statements. Financial statements are audited annually, with the most recent audit completed for the fiscal year ending in 2016. DFR will administer the ORP in accordance with its existing accounting, auditing, and reporting procedures. Auditing and reporting obligations of participating insurers will be established by rule.

DCBS is audited annually by the Audits Division of Oregon's Secretary of State. The ORP will also be subject to audit by the Audits Division. The federal government is responsible for

calculating the savings resulting from this waiver and for ensuring that this waiver does not increase federal spending.

D. State Reporting Requirements and Targets

DCBS will assume responsibility for the reporting requirements of 45 CFR 155.1324, including the following:

- Quarterly reports [45 CFR 155.1324(a)]: To the extent required, DCBS will submit quarterly reports, including reports of ongoing operational challenges, if any, and plans for, and results of, associated corrective actions.
- Annual reports [45 CFR 155.1324(b)]: DCBS will submit annual reports documenting the following:
  (1) The progress of the waiver.
  (2) Data, similar to that contained in Attachment 1, on compliance with Section 1332(b)(1)(B) through (D) of the ACA.
  (3) Modifications, if any, to the essential health benefits for compliance with Section 1332(b)(1)(A) of the ACA.
  (4) The premium for the second lowest-cost silver plan under the waiver and an estimate of the premium as it would have been without the waiver for a representative consumer in each rating area.
  (5) A summary of the annual post-award public forum required by 45 CFR 155.1320(c) together with a summary of action taken in response to public input.
  (6) Any additional information required by the terms of the waiver.

To the extent that quarterly reporting is required under 45 CFR 155.1324(a), DCBS recommends that such reporting starts no sooner than April 30, 2019, in order to provide some experience with the program about which to report. DCBS will submit and publish annual reports by the deadlines established in 45 CFR 155.1324(c) or the deadlines established by the terms of the waiver.

VI. Supporting Information and Miscellaneous

A. 45 CFR 155.1308(f)(4)(i) – (iii)

The supporting information required by 45 CFR 155.1208(4)(i) – (iii), including the actuarial analyses and certifications, the economic analyses, the detailed deficit neutral 10-year budget plan, and the data and assumptions demonstrating that the proposed waiver is in compliance with 1332(b)(1)(A) – (B) are found in Attachment 1.

B. Petition for Referendum

DCBS is closely monitoring a petition that has been filed with the Oregon Secretary of State's Office to refer to the voters several provisions of HB 2391, including a portion of the funding for

the reinsurance program. If the petitioners of this referendum submit the required number of signatures (58,789) by Oct. 5, 2017, the referendum will be placed on the ballot for voters to adopt or reject. This vote would occur on Jan. 23, 2018. DCBS is developing contingency plans related to this referendum and the impact it may have on plan year 2018 rates.

VII. Public Comment and Tribal Consultation

A. Public Comment

On July 25, 2017, DCBS opened public comment on this waiver request and posted notice of the opportunity to comment on the Marketplace's website at http://healthcare.oregon.gov/Pages/reports-audits.aspx. On the same day, DCBS sent notice via email to its list of interested parties and stakeholders (see Attachment 3). The list is comprised of more than 440 individuals and organizations with an expressed interest in insurance-related matters.

On Aug. 24, 2017, DCBS held a public hearing in Conference Room 260 in the Labor and Industries Building at 350 Winter St. NE in Salem, Oregon. At the public hearing, one member of the public testified. This testimony was also submitted in writing (see Attachment 4).

On Aug. 25, 2017, DCBS held an additional public hearing in the Pine Room of the Lincoln Building at 421 SW Oak St. in Portland, Oregon. Members of the public neither attended nor testified at this hearing.

DCBS received three written public comments on this waiver request (see Attachments 4 through 6). The public comment period closed at 5 p.m. Aug. 27, 2017.

B. Tribal Consultation

On Aug. 7, 2017, DCBS sent notice via email to representatives of all federally recognized tribes in Oregon of the opportunity for tribal consultation. Oregon's draft application and tribal consultation letter were included as attachments to the email (see Attachment 7, which includes the email and the tribal consultation letter). Because the draft application is 82 pages, it was not included as part of Attachment 7.

On Aug. 23, 2017, at the Tribal Health and Human Services Cluster meeting, representatives of the tribes were reminded of the opportunity for tribal consultation. This meeting is held quarterly and is typically attended by representatives of all federally recognized tribes in Oregon.

On Aug. 25, 2017, DCBS held tribal consultation in the Pine Room of the Lincoln Building at 421 SW Oak St. in Portland, Oregon. DCBS provided the opportunity for consultation in person and via telephone. Federally recognized tribes did not participate in the tribal consultation.

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State of Oregon

Section 1332 State Innovation Waiver
Actuarial and Economic Analysis

August 28, 2017

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Appendices

Introduction

The individual health insurance market in the state of Oregon (Oregon) has shown symptoms of destabilization in recent years. It has experienced issuers leaving the market, the termination of both of its consumer operated and oriented plans (Co-ops), and rate increases in excess of 20%. In order to mitigate further potential destabilization, Oregon is submitting a Section 1332 State Innovation Waiver ("1332 waiver" or "waiver"). The Affordable Care Act (ACA) permits states to waive certain provisions of the ACA in order to increase access to affordable coverage. However, in order for both of the Secretaries of Health and Human Services (HHS) and Treasury to approve of the waiver, the state must complete an application in which it demonstrates that it has met the regulatory requirements.

Pursuant to 45 CFR 155.1308(f)(4)(i)-(iii), in order for Oregon's 1332 waiver to be approved, the state must demonstrate that the waiver does not interfere with the four "guard rails". The four guard rails are defined as:

1) Coverage (there must be at least a comparable number of individuals with coverage under the waiver);

2) Affordability (waiver must not increase out of pocket spending including premiums and cost sharing);

3) Comprehensiveness (the waiver should not decrease the number of individuals with coverage that meets the essential health benefits (EHB) benchmark); and

4) Deficit neutrality (the waiver should not increase the federal deficit).

The waiver, as proposed, would reduce premiums through the introduction of a state-based reinsurance program starting in 2018. The reinsurance program would operate similarly to the Transitional Reinsurance program under the ACA that existed from 2014 to 2016 in that it would reimburse carriers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2018, Oregon has set the reinsurance cap at $1 million, coinsurance at 50%, and the attachment point will be set such that total estimated reinsured dollars match the funding available. If 2018 experience is worse than expected and the funding is not sufficient, the coinsurance for all carriers will be lowered. If the 2018 experience is better than expected, Oregon will determine what to do with the excess funding.

The reinsurance program will be funded, contingent on approval of the 1332 waiver, through an assessment on commercial health insurers and federal funds. In 2018, it is expected that an assessment

of 0.3% is directly attributable to the reinsurance program, per Oregon.[1] This funding is anticipated to provide $90 million in 2018 to reimburse individual market insurers for high-cost enrollees.

The goals of the reinsurance program are to remove the volatility of high cost claimants from being solely the risk of any one carrier as well as to lower premiums for the individual market in total (as the reinsurance funding will come partially from sources outside the individual market). In doing so, the reinsurance program would incentivize enrollees to join or remain in the market, encourage issuer participation, and reduce overall instability. In addition to providing lower premiums to residents of Oregon, the reinsurance program would also reduce federal outlays through lower premium tax credits.

As part of its 1332 waiver, Oregon is requesting federal funds as a way of offsetting some of the costs incurred by the reinsurance program. Oregon's reinsurance program will reduce premiums for those purchasing insurance coverage in the individual market. It will also reduce the amount of Advance Premium Tax Credits (APTCs) Oregonians receive over the next ten years. APTCs are subsidies for eligible enrollees that can be used to reduce the cost of premiums for plans purchased through the Exchange. The amount of APTCs available for eligible consumers are benchmarked to the second lowest cost silver plan (SLCSP) available on the Exchange. If premiums are reduced (including the SLCSP), then the amount the Federal Government will be required to pay in APTCs will also be reduced.

This report demonstrates that the savings on aggregate APTC amounts exceed lost federal revenue that may result from the reinsurance program. Furthermore, the reinsurance program will not reduce but rather should improve Oregonians' access to affordable and comprehensive coverage. The waiver requests that Oregon receive the amount of federal savings from APTCs, net of other costs, as a result of the reinsurance program.

This document has been prepared for the sole use of the management of Oregon. Wakely Consulting Group LLC (Wakely) understands that the report will be made public and used in the 1332 waiver process. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

This actuarial report is a supplement to Oregon's 1332 waiver report. It addresses section 45 CFR 155.1308(f)(4)(i)-(iii) of the checklist for the 1332 waiver, including actuarial analyses and actuarial certifications, economic analyses, and data and assumptions. Other sections of the waiver contain the

[1] The majority of the assessment funds will be used for purposes of the Oregon Health Plan. https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/HB2391/A-Engrossed

non-actuarial portions of the 1332 waiver requirement. Reliance on this report should include a review of the full report by qualified individuals.

Analysis Results

As described previously, the four guard rails of an approved 1332 waiver application are: 1) Coverage Requirement; 2) Affordability Requirement; 3) Comprehensiveness Requirement; and 4) Deficit Neutrality.

Wakely's analysis estimated that the waiver meets each of the four guard rails not only in 2018 but in each subsequent year over the 10-year window. The high-level 2018 guard rail results are shown in Table 1. Additional information regarding the guard rail results is found in Appendix C.

Table 1: 2018 High-Level Guard Rail Results

Guardrail	Effect of Waiver
Coverage	Increase in enrollment
Affordability (2018)	Premiums reduced 7.0% to 7.9% (net of a 0.3% assessment)
Comprehensiveness	No change to EHBs
Deficit Neutrality (2018)	Federal savings between $31.8 million and $33.4 million in 2018
Deficit Neutrality (10-year)	Federal savings each year of 10-year window

Coverage, Affordability, and Comprehensiveness

The reinsurance program is expected to decrease premiums in the non-group market. The reduction in premiums should increase overall coverage. Existing research from Congressional Budget Office (CBO)[2] as the Council of Economic Advisors[3] has noted that premiums decreases should result in enrollment increases. As the reinsurance program has no impact of other cost-sharing, the decreased premiums also improves affordability for consumers. Similarly, the reinsurance program would have no effect on the comprehensiveness of coverage. EHB requirements will not be affected by the reinsurance program. Individuals purchasing coverage in the non-group market would have the same benefits with the reinsurance program as they would without it.

[2] http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf
[3]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

Deficit Impact

The following tables display the impact of the reinsurance program on Oregon's individual market both for 2018 and for the 10-year deficit window. Based on the best estimate assumptions, in 2018, the waiver reduces premiums by 7.5% (net of a 0.3% assessment), increases non-group enrollment by 1.7%, and creates $32.9 million in federal savings (which incorporates APTC savings net of other federal revenue). These results are shown in Table 2. The results are similar for years 2019 – 2027 as is shown in Appendix C.

Table 2: 2018 Impact of Waiver on Premium, Enrollment, and Federal Deficit

	Premiums	Non-Group Enrollment	Federal Savings
Effect of Reinsurance	-7.5%	+ 1.7%	$32.9 million

Over the 10-year window, the reinsurance program provides savings to the Federal Government due to APTC savings net of other federal revenues. The details of the federal savings over the 10-year window are shown in table 3.

Table 3: 10-Year Deficit Impact of Reinsurance Program

Category of Impact	Impact to Federal Deficit Savings/Costs
Difference in APTCs	$385.6 million
Difference in Individual Shared Responsibility Payment	-$4.3 million
Difference in Exchange User Fees	-$11.8 million
Difference in Health Insurance Providers Fee	-$12.9 million
Total Savings over 10-Year Window	**$356.6 million**

Data and Methodology

The following steps were taken to estimate the impact of a state-based reinsurance program on Oregon's individual market both for 2018 and for the 10-year deficit window.

1. Wakely's model incorporates 2016 calendar year experience as base data, which was provided by Oregon carriers via their EDGE XML data files. 2016 premiums, claims, and enrollment were summarized to create a baseline picture of Oregon's market. The summarized amounts are shown in Table 4.

Table 4: 2016 to 2018 Baseline Average Enrollment and Premium Data / Estimates

Baseline	2016	2017	2018
Average Annual Enrollment			
Total Non-Group Enrollment	221,072	207,060	200,793
Exchange Enrollment	121,414	126,881	125,032
APTC Enrollment	86,623	93,322	93,322
Non-APTC Exchange Enrollment	34,791	33,559	31,710
Off-Exchange Enrollment	99,658	80,179	75,761
Total Non-APTC Enrollment	134,449	113,738	107,471
Per Member Per Month (PMPM) Amounts			
Total Non-Group Premium PMPM	$352.84	$436.02	$507.57
Exchange Premium PMPM	$370.97	$462.05	$537.87
APTC PMPM	$251.67	$345.35	$424.68
Total Annual Dollars			
Total Non-Group Premiums	$936,034,236	$1,083,383,157	$1,222,995,400
Total APTCs	$261,604,925	$386,744,863	$475,581,251

2. The 2018 enrollment, premium, and APTC amounts were calculated using the most recently available 2018 rate filing increases recommended by the state as of July 3, 2017 as well as 2017 data from the Center for Medicaid and Medicare Services (CMS) and Oregon.

    a. The state average premium was based on the 2016 EDGE data and trended by observed premium increases in 2017 (to estimate 2017) and by Oregon's recommended 2018 rating filing increases (to estimate 2018).

    b. To estimate the average 2018 APTC amounts, Wakely used the most recently available information from CMS on effectuated enrollment in 2017[4] and trended it based on 2018 rate filing information on the change in SLCSP.

[4] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

c. The 2018 individual market enrollment was calculated using 2017 data from CMS and Oregon[5] and adjusted to account for changes in enrollment due to net attrition throughout 2017 and expected 2018 premium changes, as discussed in Appendix A.

The estimated 2018 information is shown in Table 5.

3. To estimate the effects of the reinsurance program, Wakely assumed that $90 million dollars would be spent to reduce premiums in 2018. None of the funds were assumed to cover administrative costs for Oregon to operate the program. Wakely received this funding estimate from Oregon. To calculate the amount that premiums would be reduced due to the implementation of the reinsurance program, Wakely first took the aggregate premiums for the individual market, reduced them by $90 million, and increased them by 0.3%, which is the portion of the assessment attributable to reinsurance in 2018. The best estimate assumptions resulted in a reduction in premiums of 7.4% due to the reinsurance program and overall premium decreases of 7.1% when taking into account the 0.3% assessment applicable to reinsurance.

Table 5: Projected 2018 Average Enrollment and Premium Amounts, After Reinsurance

After Reinsurance	
Reinsurance Funding	$90,000,000
Reduction in Premiums (Reinsurance Funding)	-7.4%
Reinsurance Assessment	0.3%
Reduction in Premiums (Improved Morbidity)	-0.4%
Total Non-Group Premium PMPM	$469.65
Exchange Premium PMPM	$497.68
APTC PMPM	$392.95
Change in Total Non-Group Enrollment	1.7%
Total Non-Group Enrollment	204,162
Exchange Enrollment	126,026
APTC Enrollment	93,322
Total Premiums	$1,150,603,237
Total APTCs	$440,047,877

[5] Exchange enrollment was derived from the Effectuated Enrollment report (ibid). Off-Exchange data was derived from Oregon's quarterly enrollment report http://dfr.oregon.gov/business/report-data/Pages/health-ins-enroll.aspx

4. Enrollment was re-estimated with the lower post-reinsurance premium, using an enrollment function (Appendix A contains additional information regarding the enrollment function), to calculate a final individual market average enrollment per scenario. The results for the best estimate scenario are shown in Table 5.

5. Given the enrollment with the reinsurance program is estimated to be higher than without the reinsurance program, Wakely estimated the impact to the morbidity of the market due to the implementation of the reinsurance program.

    a. A health reform study from Massachusetts[6] indicated that enrollees who leave the market have costs that are approximately 73% of compared to those who remain. This relationship was applied to enrollees who remain in the market due to the lower premiums caused by the reinsurance program but would have left without the implementation of the reinsurance program.

    b. The result is an additional 0.4% reduction in average costs due to the improved morbidity of the covered population from the lower premiums under the reinsurance program.

    c. Applying the additional 0.4% reduction to the net 7.1% reduction in premiums (from the $90 million in reinsurance funding and the 0.3% assessment applicable to reinsurance) results in an overall premium reduction estimate of 7.5% (under the best estimate scenario). The results of the best estimate can be seen in Table 5.

    d. After reducing the premium impact by an additional 0.4%, Wakely again applied the enrollment function (described in item 4). It resulted in an additional 0.1% increase in enrollment, causing the total enrollment growth from the baseline to be 1.7%. No further iterations were done based on the relationship between change in enrollment and change in morbidity based on the negligible results of this iteration.

    e. The amount that Oregon reduced the issuer premiums due to the reinsurance program based on rate decisions as of July 3, 2017 was 7.2%, which included the impact of removing $90 million from the market and the 0.3% assessment

6. These figures, along with other claims assumptions, were used to estimate the reinsurance parameters that would produce $90 million in claims coverage. Additional information on the reinsurance parameters is in Appendix B.

[6]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

7. The following were the assumptions incorporated for the 10-year estimates:

    a. Premiums were trended using National Health Expenditure Data from CMS[7].

    b. The individual market enrollment was assumed to have reached steady state in 2018.

    c. In 2019, reinsurance was equal to $95 million. Starting in 2020, reinsurance funding amounts were trended, each year, to align with increases in premiums and underlying claims costs.

    The results of these assumptions, such as enrollment (both in total and various distributions), changes to the SLCSP, and impact on the federal deficit are discussed in Appendix A and Appendix C.

Scenario Testing

Wakely performed scenario testing which involved changing the enrollment and premium assumptions for 2018. These two assumption were chosen for scenario testing as they are significant drivers of the results of the analysis. We tested for scenarios in which enrollment was higher than (high scenario), equal to (constant scenario), and lower than (reactive scenario) 2017. We also tested for scenarios in which premiums were equal to Oregon's recommended rates as of July 3rd (rate filings scenario) or lower than the recommended rates (low scenario). Further detail regarding the scenario testing can be found in Appendix A and Appendix C.

The high-level results of the scenario testing are shown in Table 6, with the total reduction in premiums (including the morbidity impact and the 0.3% assessment). Although a variety of alternative scenarios were tested, the basic conclusions did not alter significantly from the best estimate scenarios.

[7] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/ - Table 17. Premiums were trended by spending per enrollee for direct purchase.

Table 6: High-Level Results of Scenario Testing

Scenario	1	2	3	4	5	6
Enrollment	Constant	Reactive	High	Constant	Reactive	High
Premiums	Rate Filings	Rate Filings	Rate Filings	Low	Low	Low
Total Reduction in Premiums	-7.2%	-7.5%	-7.0%	-7.6%	-7.9%	-7.4%
Estimated Net Federal Savings	$31,816,345	$32,866,704	$33,312,665	$31,857,135	$32,907,853	$33,359,779

These results imply that Oregon's reinsurance program would reduce premiums, increase coverage, and provide federal savings, even if the projections vary from Wakely's best estimate. Scenario 2 in the table represents the best estimate assumptions. As of July 3rd, 2017, Oregon is incorporating a 7.2% reduction (net of the 0.3% assessment) in issuer premiums to account for the reinsurance program.

Appendix A

Data and Methodology

2018 Baseline Enrollment and Premium Estimates

To create the baseline estimates, Wakely completed the following steps:

1. Wakely summarized the 2016 EDGE premium, claims, and enrollment data, which was used as the base data.[8] The data was compared to Oregon and CMS reports to confirm consistency. Wakely also relied upon Oregon and CMS reports for data that was not available in the EDGE files. Several key data points, such as APTC enrollment and dollar amounts, were verified using both data provided by the carriers and CMS reports.

2. Using publicly available data, estimates were made for 2017 average enrollment.

    a. 2017 off-Exchange enrollment was estimated using Oregon quarterly data[9] measured as of March 2017, which captures effectuated enrollment. The data was then adjusted for expected within year net attrition, based on observed attrition in 2016, to produce average off-Exchange enrollment for 2017.

    b. 2017 on-Exchange enrollment was measured using 2017 CMS' Effectuated Enrollment Data as of February 2017 adjusted to account for within year net attrition, based on 2016 average enrollment, as reported in CMS' Effectuated Enrollment Report, to produce a yearly on-Exchange enrollment average. Analysis of 2018 rate filings were also used to confirm issuer expectations of the enrollment distribution between on and off-Exchange enrollment.

    c. The number of enrollees with APTCs in 2017 was measured using CMS' Effectuated Enrollment report[10] and then adjusted for expected within year net attrition, based on 2016 net attrition, to produce an estimated average enrollment in 2017.

3. Overall enrollment in 2018 was estimated using a non-linear enrollment response function estimated by the Council of Economic Advisors (CEA take-up function).[11] The function computes

[8] A more thorough description of EDGE data requirements is found in Appendix E.

[9] http://dfr.oregon.gov/business/report-data/Pages/health-ins-enroll.aspx

[10] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

[11] https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

expected enrollment change based on premium rate increases and portion of the market that is not receiving subsidies. The resulted in a decrease of 3.0% compared to 2017. 2018 APTC enrollment was assumed to be consistent with 2017 enrollment, as these enrollees would not experience a net premium change. The result of these two assumptions is that enrollment changes would occur among the unsubsidized portion of the non-group market. The changes in enrollment were distributed pro rata between on-Exchange and off-Exchange by the share of unsubsidized enrollment that on-Exchange enrollees represented.

4. For 2018, premiums were estimated using the 2016 EDGE data trended forward using 2017 Exchange premium increases (weighted by March 2017 enrollment) and 2018 rate filing increases recommended by the state as of July 3, 2017 (weighted by March 2017 enrollment). On-Exchange premiums were based on the 2017 CMS' Open Enrollment report and trended using the 2018 rate filing increases recommended by the state as of July 3, 2017 (weighted on March 2017 enrollment). Average APTC amounts were estimated using CMS' Effectuated Enrollment report and trended using the increase in the SLCSP, as estimated by the 2018 rate filing increases recommended by Oregon as of July 3, 2017. In addition, all 2018 premiums and APTC amounts were increased by 1.2% to account for the assessment that Oregon recently passed on health care premiums and hospitals to provide funding for Medicaid starting in the 2018 benefit year.[12] These assumptions, in totality, were used to generate baseline estimates as can be seen in Table 7.

[12] https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/HB2391/A-Engrossed

Table 7: 2016 - 2018 Baseline Average Enrollment and Premium Data / Projections

	2016	2017	2018
Average Annual Enrollment			
Total Non-Group Enrollment	221,072	207,060	200,793
Exchange Enrollment	121,414	126,881	125,032
APTC Enrollment	86,623	93,322	93,322
Non-APTC Exchange Enrollment	34,791	33,559	31,710
Off-Exchange Enrollment	99,658	80,179	75,761
Total Non-APTC Enrollment	134,449	113,738	107,471
PMPM Amounts			
Total Non-Group Premium PMPM	$352.84	$436.02	$507.57
Exchange Premium PMPM	$370.97	$462.05	$537.87
APTC PMPM	$251.67	$345.35	$424.68
Total Annual Dollars			
Total Non-Group Premiums	$936,034,236	$1,083,383,157	$1,222,995,400
Total APTCs	$261,604,925	$386,744,863	$475,581,251

2018 Waiver Effects

The impact of the $90 million in reinsurance funding (as discussed previously) as a reduction to premiums was estimated by dividing the total reinsurance funding amount of $90 million by the total estimated 2018 baseline individual market. This resulted in an approximate 7.4% reduction to premiums. In addition, an adjustment was made to account for younger, healthier members remaining covered due to the implementation of the reinsurance program. This reduced premiums another 0.4%. The decreases in premiums is partially offset by the 0.3% assessment for the program (as discussed previously). The premium adjustments due to reinsurance were made equally to APTC amounts, on-Exchange premiums, and off-Exchange premiums.

The decrease in premiums is expected to produce an increase in enrollment relative to what Oregon would experience without the reinsurance program. Enrollment changes were estimated using the CEA take-up function (as discussed previously). APTC enrollment is assumed to stay the same as 2017 since these members are generally unaffected by rate changes.[13] Consequently, the new enrollees are expected

[13] This assumption does not preclude normal churn that occurs within the individual market. Normal churn, enrollees leaving for employer-sponsored insurance or enrollees joining the individual market who previously had coverage in

to be above 400% FPL. These new enrollees were allocated pro rata between on-Exchange and off-Exchange by the share of unsubsidized enrollment that on-Exchange enrollees represented. It is likely that enrollees who stay in the market due to the implementation of reinsurance will be healthier and/or younger than the enrollees who will be in the market regardless of whether there is a reinsurance program.[14] These results were discussed previously and are shown in Table 8.

Table 8: Projected 2018 Average Enrollment and Premium Amounts, After Reinsurance

After Reinsurance	
Reinsurance Funding	$90,000,000
Reduction in Premiums (Reinsurance Funding)	-7.4%
Reinsurance Assessment	0.3%
Reduction in Premiums (Improved Morbidity)	-0.4%
Total Non-Group Premium PMPM	$469.65
Exchange Premium PMPM	$497.68
APTC PMPM	$392.95
Change in Total Non-Group Enrollment	1.7%
Total Non-Group Enrollment	204,162
Exchange Enrollment	126,026
APTC Enrollment	93,322
Total Premiums	$1,150,603,237
Total APTCs	$440,047,877

As shown in Table 9, the effect of the proposed waiver will have minimal impact on distribution of enrollment by Federal Poverty Level (FPL). Wakely used 2017 CMS data on FPL distribution[15] to estimate on-Exchange enrollment. Off-Exchange enrollees were assumed to be above 400% FPL. HHS reports noted that approximately 20,000 off-Exchange members were APTC eligible in 2016. Given the dramatic shift in off-Exchange enrollment in 2017 (see Table 7), we assumed that only a negligible number of enrollees off-Exchange were below 400% FPL. We also estimated that additional enrollees gaining coverage as a result of the lower premiums due to the 1332 waiver would have income above 400% FPL as this group would

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Medicaid, would continue. The assumption merely assumes in aggregate that a similar number of APTC enrollees would have coverage in 2018 as had coverage in 2017.

[14]https://www.brookings.edu/blog/up-front/2017/02/08/new-data-on-sign-ups-through-the-acas-marketplaces-should-lay-death-spiral-claims-to-rest/

[15]https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html.

be most impacted by changes in gross premium. For additional information on the distribution of enrollment by FPL for the 5-year window, see Appendix D. Given the assumption that overall enrollment was in steady state, we assumed that the general distribution of enrollment was similarly constant. Within the alternative scenario, we relax some of these assumptions to allow for greater buy-down.

Table 9: 2017-2018 Average Enrollment (Baseline and After Reinsurance) by FPL

	2017	2018	
FPL Level	Baseline	Baseline	Reinsurance
Total Non-Group Enrollment	207,060	200,793	204,162
Total Non-Group APTC Eligible	93,322	93,322	93,322
<100% of FPL	2,037	2,007	2,007
≥100% to ≤150% of FPL	9,756	9,614	9,614
>150% to ≤200% of FPL	30,136	29,697	29,697
>200% to ≤250% of FPL	23,308	22,968	22,968
>250% to ≤300% of FPL	15,877	15,645	15,645
>300% to ≤400% of FPL	20,735	20,433	20,433
>400% of FPL	105,211	100,429	103,797

Metal level enrollment was estimated using initial 2018 issuer rate filings. The post-waiver metal level distribution was estimated directly from the reinsurance parameters analysis.[16] As Table 10 shows, the 1332 waiver produces a minimal shift in metal level distribution between the baseline estimates and the after reinsurance estimates; however, slightly larger shifts are seen in bronze and silver metal levels as would be expected due to reinsurance. It is likely that the enrollees who would maintain coverage due to the reinsurance program, but would leave the market without the reinsurance program, are younger and healthier, and therefore attracted to lower actuarial value plans. It is also possible that lower premium increases reduce buy-down rates. For additional information on the distribution of enrollment by metal for the 5-year window, see Appendix D.

[16] See Appendix B for further details

Table 10: 2017-2018 Average Enrollment (Baseline and After Reinsurance) by Metal

Metal Level	2017 Baseline	2018 Baseline	2018 Reinsurance
Total Non-Group Enrollment	207,060	200,793	204,162
Catastrophic	897	870	868
Bronze	65,571	63,587	64,979
Silver	114,196	110,740	112,496
Gold	26,395	25,596	25,819
Platinum	-	-	-

The 2017 and 2018 SLCSP by rating area were identified from the 2017 and 2018 issuer rate filings, respectively. Due to the timing of the 2018 rate reviews, Wakely had to estimate the 2018 SLCSP based on the initial 2018 rate filings and the 2018 rate filing increases recommended by the state as of July 3, 2017. While rates are ultimately developed at a service area level, the data was aggregated to align with rating area, which may cause slight variations from actual SLCSP rate changes year over year. Weighted by 2016 total individual market enrollment at the rating area level, Wakely estimates that the SLCSP premium rates will increase by 23% from 2017 to 2018 (excluding the effects of reinsurance, but including the 1.2% assessment for Medicaid, as discussed previously). The SLCSP rates after reinsurance were calculated by taking the associated base line rates and reducing them by the reduction in premium due to reinsurance, net of the assessment (or approximately 7.5%). The resulting SLCSP premium PMPMs are shown in Table 11. For future years SLCSP was trended at the same rate as premiums based on National Health Expenditure data. [17] For additional information on the SLCSP by rating area for the 10-year window, see Appendix D.

[17] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/ Table 17. Premiums were trended by spending per enrollee for direct purchase.

Table 11: 2017-2018 Second Lowest Silver Premium PMPMs By Rating Area (21 Year Old, Non-Tobacco)

Rating Area	2017 Baseline	2018 Baseline	2018 Waiver	Baseline Change by Rating Area
1	$244	$296	$274	21%
2	244	300	278	23%
3	244	300	278	23%
4	298	369	341	24%
5	244	300	278	23%
6	244	300	278	23%
7	283	369	341	30%
Total	**$252**	**$310**	**$287**	**23%**

Alternative Scenarios

Wakely estimated five additional 2018 scenarios to analyze the robustness of the initial 2018 findings. The scenarios included a combination of three enrollment scenarios and two premium scenarios.

The following were the enrollment scenarios that were modeled:

- 2018 enrollment lower than 2017 enrollment, as estimated by the CEA take-up function. This scenario is labeled as “reactive” in table 12.
- 2018 enrollment equal to 2017 enrollment. This scenario is labeled as “constant” in table 12.
- 2018 enrollment higher in 2018 than 2017 enrollment. This scenario is labeled as “higher” in table 12. For this scenario, off-Exchange enrollment was held constant. On-Exchange enrollment and APTC enrollment was increased by the rate of growth between 2016 and 2017 as documented in CMS’ Effectuated Enrollment report.

One of two premium scenarios were used in conjunction with the enrollment scenarios. The Medicaid assessment of 1.2% was included in both scenarios. The following are the premium scenarios:

- The 2018 rate filing increases recommended by the state as of July 3, 2017 representing the rate at which premiums and APTCs would increase. This scenario is labeled as "rate filings" in table 12.[18]

- Premiums would increase at a rate 5% lower than the 2018 rate filing increases recommended by the state as of July 3, 2017 (which is approximately 15%). APTC amounts would similarly increase at a rate 5% lower than the 2018 rate filing increases by the state as of July 3, 2017. This scenario is labeled as "low" in table 12. It is possible that enrollees shopping for lower priced plans ("buy-down") could produce overall premiums increases less than what is currently measured in the rate filings.

For each of the scenarios, the same reinsurance methodology was applied as was used in the baseline scenario: $90 million in reinsurance funding was applied to the individual market, the 0.3% assessment was added, and enrollment was re-estimated using the CEA take-up function. Each scenario produced a decrease in the state average premiums PMPM in 2018 between 7.0% and 7.9% (net of the 0.3% assessment). In each scenario, the lower premiums resulted in more enrollees in the individual market. Finally, in each scenario, the combined lower premiums (including decreased APTC PMPMs) resulted in between approximately $31.8 million and $33.4 million fewer dollars being spent in 2018 as a result of the reinsurance program. The detailed results of the scenario testing is shown in table 12.

Scenario 2 is the best estimate scenario including reactive enrollment and premiums to match Oregon's recommended premium increases. This scenario was used for the 10-year economic analysis.

[18] Rate Filings were measured as of 7/03/2017.

Table 12: Summary of Alternative Scenario Results for 2018

Scenario	1	2 – Best Estimate	3	4	5	6
Enrollment	**Constant**	**Reactive**	**High**	**Constant**	**Reactive**	**High**
Premiums	**Rate Filings**	**Rate Filings**	**Rate Filings**	**Low**	**Low**	**Low**
Baseline						
Total Non-Group Enrollment	207,060	200,793	212,997	207,060	200,793	212,997
Exchange Enrollment	126,881	125,032	132,818	126,881	125,032	132,818
APTC Enrollment	93,322	93,322	100,539	93,322	93,322	100,539
Total Non-Group Premium PMPM	$507.57	$507.57	$507.57	$483.40	$483.40	$483.40
Exchange Premium PMPM	$537.87	$537.87	$537.87	$512.26	$512.26	$512.26
APTC PMPM	$424.68	$424.68	$424.68	$404.46	$404.46	$404.46
Total Non-Group Premiums	$1,261,165,673	$1,222,995,400	$1,297,329,549	$1,201,110,165	$1,164,757,524	$1,235,551,951
Total APTCs	$475,581,251	$475,581,251	$512,360,158	$452,934,524	$452,934,524	$487,962,055
After Reinsurance						
Reinsurance Funding	$90,000,000	$90,000,000	$90,000,000	$90,000,000	$90,000,000	$90,000,000
Reduction in Premiums (Reinsurance Funding)	-7.1%	-7.4%	-6.9%	-7.5%	-7.7%	-7.3%
Reinsurance Assessment	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Reduction in Premiums (Improved Morbidity)	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%
Total Premium Impact	-7.2%	-7.5%	-7.0%	-7.6%	-7.9%	-7.4%
Total Non-Group Premium PMPM	$470.79	$469.65	$471.93	$446.55	$445.40	$447.69
Exchange Premium PMPM	$498.90	$497.68	$500.11	$473.21	$472.00	$474.42
APTC PMPM	$393.90	$392.95	$394.86	$373.62	$372.66	$374.58
Percent Change in Total Enrollment	1.7%	1.7%	1.6%	1.8%	1.8%	1.6%
Total Non-Group Enrollment	210,513	204,162	216,300	210,702	204,346	216,480
Exchange Enrollment	127,900	126,026	133,766	127,955	126,080	133,818
APTC Enrollment	93,322	93,322	100,539	93,322	93,322	100,539
Total Premiums	$1,189,286,565	$1,150,603,237	$1,224,941,794	$1,129,059,223	$1,092,196,949	$1,162,988,100
Total APTCs	$441,119,306	$440,047,877	$476,385,661	$418,404,959	$417,333,784	$451,914,390
Savings						
Estimated APTC Savings	$34,461,945	$35,533,373	$35,974,498	$34,529,566	$35,600,740	$36,047,665
Estimated Net Federal Savings	$31,816,345	$32,866,704	$33,312,665	$31,857,135	$32,907,853	$33,359,779

Beyond 2018

For years beyond 2018, Wakely made the following assumptions:

- Baseline premiums (both total non-group and on-Exchange) as well as APTC amounts were trended by the Office of the Actuaries National Health Expenditure spending for each year of the 10 year window.[19]
- Premiums were further adjusted for the changes in the Medicaid assessment. They are scheduled to decrease to 0.6% of premiums in 2019 and cease in 2020.
- Enrollment was assumed to be constant starting in 2019 absent the waiver. This is generally in line with CBO projections and HHS publications that the non-group market will generally be at "steady-state" in the 10-year time frame.[20]
- While reinsurance funding is not legislatively approved in the out years, for purposes of the analysis, it is assumed that the reinsurance program will continue. It is expected to be funded at $95 million for 2019 by Oregon and then the amounts were increased at the rate of premium growth.
- The reinsurance assessment was increased from 0.3% in 2018, to 0.9% in 2019, and 1.5% in 2020 and thereafter.

For each year, the same methodology of applying reinsurance, calculating the change in premiums and APTC amounts as a result of reinsurance, and calculating the change in enrollment as a result of lower premium was used consistently to that described for 2018. This results in a constant net reduction in premiums of 6.4% each year between 2020 and 2027. The detailed results are shown in table 13.

[19] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/ Table 17. Premiums were trended by spending per enrollee for direct purchase.

[20] https://aspe.hhs.gov/system/files/pdf/77161/ib_Targets.pdf ; https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf

Table 13: Baseline Data and Detailed Results after Reinsurance, by Year[21]

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Baseline										
Total Non-Group Enrollment	200,793	200,793	200,793	200,793	200,793	200,793	200,793	200,793	200,793	200,793
Exchange Enrollment	125,032	125,032	125,032	125,032	125,032	125,032	125,032	125,032	125,032	125,032
APTC Enrollment	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322
Total Non-Group Premium PMPM	$507.57	$529.77	$551.36	$578.38	$607.30	$637.05	$668.27	$700.35	$734.56	$770.45
Exchange Premium PMPM	$537.87	$561.40	$584.28	$612.91	$643.55	$675.09	$708.17	$742.16	$778.42	$816.45
APTC PMPM	$424.68	$443.25	$461.32	$483.92	$508.12	$533.02	$559.13	$585.97	$614.60	$644.63
Total Premiums	$1,222,995,400	$1,276,486,253	$1,328,510,046	$1,393,607,039	$1,463,287,391	$1,534,988,473	$1,610,202,908	$1,687,492,648	$1,769,938,717	$1,856,412,866
Total APTCs	$475,581,251	$496,382,021	$516,612,302	$541,926,305	$569,022,620	$596,904,729	$626,153,060	$656,208,407	$688,268,875	$721,895,726
After Reinsurance										
Reinsurance Funding	$90,000,000	$95,000,000	$99,465,000	$104,338,785	$109,555,724	$114,923,955	$120,555,229	$126,341,879	$132,514,583	$138,988,867
Reduction in Premiums (Reinsurance Funding)	-7.4%	-7.4%	-7.5%	-7.5%	-7.5%	-7.5%	-7.5%	-7.5%	-7.5%	-7.5%
Reinsurance Assessment	0.3%	0.9%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Reduction in Premiums (Improved Morbidity)	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%
Total Non- Group Premium PMPM	$469.65	$492.86	$515.98	$541.27	$568.33	$596.18	$625.39	$655.41	$687.43	$721.02
Exchange Premium PMPM	$497.68	$522.28	$546.79	$573.58	$602.26	$631.77	$662.73	$694.54	$728.47	$764.06
APTC PMPM	$392.95	$412.37	$431.72	$452.87	$475.52	$498.82	$523.26	$548.37	$575.17	$603.27
Change in Total Non-Group Enrollment	1.7%	1.6%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
Total Non-Group Enrollment	204,162	203,924	203,666	203,666	203,666	203,666	203,666	203,666	203,666	203,666
Exchange Enrollment	126,026	125,956	125,879	125,879	125,879	125,879	125,879	125,879	125,879	125,879
APTC Enrollment	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322
Total Premiums	$1,150,603,237	$1,206,061,766	$1,261,057,146	$1,322,848,946	$1,388,991,394	$1,457,051,972	$1,528,447,518	$1,601,812,999	$1,680,073,006	$1,762,156,573
Total APTCs	$440,047,877	$461,795,274	$483,464,896	$507,154,676	$532,512,410	$558,605,518	$585,977,189	$614,104,094	$644,107,465	$675,576,715

[21] Please see page C-7 for total federal savings net of federal losses under the reinsurance program.

Appendix B

Reinsurance Parameters

Reinsurance Parameters

To estimate the reinsurance parameters, Wakely first had to estimate the 2018 individual market data. To do this, Wakely completed the following steps:

1. Wakely collected 2016 EDGE data from each Oregon carrier in the individual market.
2. The data was adjusted to 2018 using trend amounts found in the initial 2018 rate filing as of July 3, 2017 (weighted by 2016 EDGE data enrollment).
3. In addition to trending the data, Wakely applied a change to the enrollment and morbidity (estimated by a change in paid claims) from 2016 to 2018. Wakely determined the most appropriate methodology was to remove members from the 2016 data, aligning with the overall estimated enrollment decrease from 2016 to 2018. The enrollment was removed assuming the healthier and younger members would be more likely to drop coverage between 2016 and 2018.

In order to remove enrollment while targeting an increase in morbidity (i.e. claims PMPM) from 2016 to 2018, Wakely assigned probabilities to members based on their health (estimated by annual paid claims) and age status. Members were grouped by decile of annual paid claim amounts and age bands (with a separate age band for children and thereafter 10-year age bands). Using these two indicators, Wakely assigned a factor of likelihood that a member would leave the market. For example, a member with between the ages of 19-29 that is in the 30th percentile of claims will be more likely to leave the market than a member that is between the ages of 40-49 that is within the 80th percentile of claims. Each individual's probability of remaining in or leaving the market was then multiplied by a random factor to select a random population upon each time of running the model. Several iterations were performed to ensure that a consistent impact to the market was occurring for each set of parameters used.

The resulting 2018 data was used to determine the reinsurance parameters. In general, the methodology used to apply the reinsurance parameters parallels the methodology used for the Federal Transitional Reinsurance program under the ACA. Two examples of this include:

- Members are grouped by carrier but are allowed to accumulate claims if they change plans or rating areas within a carrier.
- Cost Share Reduction (CSR) Maximum Out of Pocket (MOOP) adjustments were also considered in developing these assumptions, consistently with how they were applied by the Federal Transitional Reinsurance program. The total paid claims necessary to hit the attachment point is increased by the difference between the MOOP from the CSR plan compared to the standard silver base plan. The purpose of this adjustment is to not double count money paid to the issuer for the difference in cost-sharing benefits that are afforded to CSR eligible members.

Using this methodology, Wakely determined the reinsurance parameters assuming a $1 million cap amount and 50% coinsurance (per input from Oregon) and solved for the attachment point targeting $87.1 million in funding. **The attachment point will continue to be revised as final rate decisions are made and assumptions are refined for 2018.**

$87.1 million was targeted rather than the $90.0 million discussed previously due to the potential underreporting of reinsurance due to the Oregon Health Co-op (Co-op) exiting the market in the middle of 2016. When the Co-op terminated business in the middle of 2016, enrollees received a special enrollment period (SEP), or the ability to select a new plan without any penalty. Based on member-level data provided by Oregon, Wakely was able to map slightly less than half of the Co-op members to their new plan in August 2016. Wakely decided to include all members from the 2016 EDGE data. For Co-op members, this consisted of a portion of members who could be linked from their Co-op plan to their new plan (and claims could be aggregated such that reinsurance could be applied), and a portion of members who could not be linked (which would include an unlinked record on each the Co-op side and the new carrier side). Wakely reviewed the members on the "new carrier side" who were potentially Co-op members but that could not be mapped directly to a Co-op record. There were many members who had large claims that could have potentially qualified for reinsurance but were not able to meet the attachment point if their prior claims were not included. We estimate the impact of this to be a maximum of $2.9 million. It is possible that this will produce a slightly more conservatively estimated attachment point.

Appendix C

Guard Rail Requirements

Scope of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage to at least a comparable number of residents as would have been provided coverage without the waiver. We expect enrollment to increase 1.7% in 2018, 1.6% in 2019 and 1.4% in subsequent years relative to what would have occurred if the reinsurance program were not in place in each year of the waiver. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least comparable number of enrollees (and most likely a greater number of individuals covered).

Affordability Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage, premiums, and cost-sharing protections that keep care at least as affordable as would be provided absent the waiver coverage to at least a comparable number of residents as would have been provided absent the waiver. Generally, we expect premiums to be approximately 7.5% lower in 2018, 7.0% lower in 2019, and 6.4% lower in subsequent years (net of the assessment) than they otherwise would have been as a direct result of the reinsurance program. Cost sharing for plans will remain within the federal requirements and should therefore not impact affordability. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least as affordable coverage for residents (and most likely greater affordability for residents).

Comprehensiveness of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that it will provide coverage that is at least as comprehensive as would be provided absent the waiver. This waiver will not result in any changes to the EHB benchmark or actuarial value requirements and, as such, will not have any impact on the comprehensive of coverage for residents.

Deficit Neutrality

APTCs

Since APTCs are benchmarked to the SLCSP, the decrease in premiums (specifically the SLCSP) will result in lower per person APTC amounts in 2018. Since enrollees who have APTCs are generally unaffected by changes in gross premiums, due to the subsidies shielding them from premium increases, the introduction of reinsurance is not expected to decrease the number of enrollees with APTCs. Due to the combination of a non-decreasing number of enrollees with APTCs and a decrease in premiums, which is connected to

APTC amounts, Wakely's analysis estimates that the overall aggregate amount of APTCs will be lower each year over the 10-year window. Wakely further estimates that the total federal savings of APTC expenditures will be in excess of $33.1 million per year. APTC savings net of other Federal losses will be in excess of $30.7 million per year. These results are shown in table 14.

Table 14: Detailed Results of Federal Savings, by Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Baseline										
Total Non-Group Enrollment	200,793	200,793	200,793	200,793	200,793	200,793	200,793	200,793	200,793	200,793
Exchange Enrollment	125,032	125,032	125,032	125,032	125,032	125,032	125,032	125,032	125,032	125,032
APTC Enrollment	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322
Total Non-Group Premium PMPM	$507.57	$529.77	$551.36	$578.38	$607.30	$637.05	$668.27	$700.35	$734.56	$770.45
Exchange Premium PMPM	$537.87	$561.40	$584.28	$612.91	$643.55	$675.09	$708.17	$742.16	$778.42	$816.45
APTC PMPM	$424.68	$443.25	$461.32	$483.92	$508.12	$533.02	$559.13	$585.97	$614.60	$644.63
After Reinsurance										
Total Non-Group Enrollment	204,162	203,924	203,666	203,666	203,666	203,666	203,666	203,666	203,666	203,666
Exchange Enrollment	126,026	125,956	125,879	125,879	125,879	125,879	125,879	125,879	125,879	125,879
APTC Enrollment	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322	93,322
Total Non-Group Premium PMPM	$469.65	$492.86	$515.98	$541.27	$568.33	$596.18	$625.39	$655.41	$687.43	$721.02
Exchange Premium PMPM	$497.68	$522.28	$546.79	$573.58	$602.26	$631.77	$662.73	$694.54	$728.47	$764.06
APTC PMPM	$392.95	$412.37	$431.72	$452.87	$475.52	$498.82	$523.26	$548.37	$575.17	$603.27
Federal Savings Calculations										
CBO Mandate Annual Penalty	$115	$111	$111	$148	$148	$148	$143	$179	$179	$179
Exchange User Fees	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Provider Tax	1.65%	1.65%	1.65%	1.65%	1.65%	1.65%	1.65%	1.65%	1.65%	1.65%
Difference in APTCs	$35,533,373	$34,586,747	$33,147,406	$34,771,629	$36,510,210	$38,299,211	$40,175,872	$42,104,314	$44,161,410	$46,319,011
Difference in Mandate Penalty	-$387,393	-$347,551	-$318,890	-$425,187	-$425,187	-$425,187	-$410,823	-$514,246	-$514,246	-$514,246
Difference in User Fees	-$1,087,212	-$1,058,003	-$1,013,719	-$1,063,391	-$1,116,560	-$1,171,272	-$1,228,664	-$1,287,640	-$1,350,551	-$1,416,535
Difference in Insurer Fees	-$1,192,065	-$1,159,664	-$1,110,731	-$1,165,157	-$1,223,415	-$1,283,362	-$1,346,247	-$1,410,867	-$1,479,798	-$1,552,096
Estimated Net Federal Savings	**$32,866,704**	**$32,021,529**	**$30,704,066**	**$32,117,894**	**$33,745,048**	**$35,419,390**	**$37,190,138**	**$38,891,561**	**$40,816,816**	**$42,836,133**

Offsets to APTC Savings

Individual Responsibility Requirement

As part of the ACA, individuals that can afford insurance but forgo insurance are generally required to pay a fee. Since a greater number of individuals would be purchasing insurance, rather than being uninsured, as a result of the reinsurance program, the Federal Government would be losing some revenue as a result of the program. The lost penalties from the mandate were estimated by multiplying the average mandate penalty paid by uninsured individuals (which was calculated using CBO estimates of mandate penalties for the uninsured, or approximately $115 in 2018)[22] by the total increase in enrollment as a result of the reinsurance program. This methodology avoids the necessity for estimating exactly the number of people that may seek exemptions from the mandate as that data would be already accounted for in CBO's penalty average. Wakely assumed enforcement of the mandate in 2018 and future years.

Wakely also estimated collections for the individual responsibility requirement using an alternative methodology. Wakely estimated what the total collections would be under a maximum cost scenario. In this scenario, all individuals that signed up for coverage as a result of the lower premiums due to the reinsurance program would have paid the mandate, and their payment would have been equal to the flat rate minimum charged to adults each year (or $737 in 2018). While an unlikely scenario, the findings demonstrate that even under extreme circumstances, the waiver would still not add to the Federal deficit. These results are shown in table 15.

[22] https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf

Table 15: Impact of Alternative Scenario for Individual Responsibility Requirement

Year	APTCs	Individual Shared Responsibility Payment	Exchange User Fee	Health Insurance Providers Fee	Total	Alternative Shared Responsibility Payment	Total with Alternative Shared Responsibility Payment
2018	$35,533,373	-$387,393	-$1,087,212	-$1,192,065	$32,866,704	-$2,482,681	$30,771,415
2019	$34,586,747	-$347,551	-$1,058,003	-$1,159,664	$32,021,529	-$2,376,497	$29,992,583
2020	$33,147,406	-$318,890	-$1,013,719	-$1,110,731	$30,704,066	-$2,246,596	$28,776,360
2021	$34,771,629	-$425,187	-$1,063,391	-$1,165,157	$32,117,894	-$2,313,994	$30,229,087
2022	$36,510,210	-$425,187	-$1,116,560	-$1,223,415	$33,745,048	-$2,383,414	$31,786,821
2023	$38,299,211	-$425,187	-$1,171,272	-$1,283,362	$35,419,390	-$2,454,916	$33,389,661
2024	$40,175,872	-$410,823	-$1,228,664	-$1,346,247	$37,190,138	-$2,528,564	$35,072,397
2025	$42,104,314	-$514,246	-$1,287,640	-$1,410,867	$38,891,561	-$2,604,420	$36,801,387
2026	$44,161,410	-$514,246	-$1,350,551	-$1,479,798	$40,816,816	-$2,682,553	$38,648,509
2027	$46,319,011	-$514,246	-$1,416,535	-$1,552,096	$42,836,133	-$2,763,030	$40,587,350
Total	**$385,609,183**	**-$4,282,956**	**-$11,793,546**	**-$12,923,401**	**$356,609,280**	**-$24,836,665**	**$336,055,571**

Exchange User Fee

Wakely acknowledges that there may be a loss of revenue for Exchange user fees (also known as user fees) due to the reduction in premium amounts. To calculate an estimate of this loss, Wakely estimated the baseline Exchange user fees to be 2% (per the 2018 HHS Payment Notice) multiplied by total Exchange premiums (using the baseline Exchange enrollment and baseline Exchange premiums). This was then compared to post-reinsurance scenarios in which enrollment and premiums were re-estimated using the lower premiums and higher enrollment as a result of the reinsurance payments. In future years, Wakely assumed that the user fee rate would stay at 2%. The results are shown in table 14.

Health Insurance Providers Fee

The reinsurance program would also impact the health insurance providers fee (also known as the insurer fee). Section 9010 of the ACA requires that a tax on health insurance providers be set at an amount totaling $14.3 billion in 2018 and increasing thereafter generally at the rate of premium increase. We estimate that Oregon's reinsurance program will have minimal impact on national premium growth rate. To estimate the decrease in collected provider fees, Wakely first estimated the baseline collection for 2018 using the 2018 draft rate filing information. Rate filing analysis yielded an estimated 1.65% provider fee on premiums. This amount was held constant over the 10-year window to align the fee with overall premium growth. To calculate the impact of the waiver, Wakely estimated the total provider fees (defined as total premiums multiplied by 1.65%) for the baseline and the waiver scenario to arrive at the federal costs due to the provider fee for the implementation of the waiver. These estimates are conservative as these losses on Oregonian issuers may be partially or fully captured by taxes on non-Oregon health insurance providers given that statutory construction of the fee. The results are shown in table 14.

Other Federal Impacts

Wakely did not directly estimate the impact of the proposed waiver on the collections related to the Cadillac tax, small business tax credit, income taxes, or CSR payments. It is unlikely that any of these would have a significant impact on the overall savings.[23]

Employer Markets

A detailed analysis of the group markets was not completed. It is not expected that the reinsurance program will have an impact on the small group, large group, federal employee health benefits program,

[23] http://mn.gov/commerce-stat/pdfs/mn-1332-actuarial-analysis.pdf

and other health programs in the state. In particular, we do not expect enrollment migration from the group market to the non-group market as a result of the reinsurance program.

Deficit Neutrality in Alternative Scenarios

In addition, Wakely calculated the impact of the federal savings under the alternative 2018 scenarios discussed previously. Wakely estimated potential effects of the reinsurance program in the event that enrollment was higher (scenario "high"), similar (scenario "constant"), and lower (scenario "reactive"). We also estimated if premiums were equal to Oregon's recommended 2018 rate filings as of July 3, 2017 (scenario "rate filings") or lower than current recommendations due to buy-down (scenario "low"). The methodologies for the enrollment and premium scenarios can be found in Appendix A. As can be seen in table 16, there was no 2018 scenario in which net federal savings, as a result of the reinsurance program, was less than $31 million.

Table 16: Estimated 2018 Federal Savings in Alternative Scenarios

Scenario	1	2	3	4	5	6
Enrollment	**Constant**	**Reactive**	**High**	**Constant**	**Reactive**	**High**
Premiums	**Rate Filings**	**Rate Filings**	**Rate Filings**	**Low**	**Low**	**Low**
Difference in APTCs	$34,461,945	$35,533,373	$35,974,498	$34,529,566	$35,600,740	$36,047,665
Difference in Mandate Penalty	-$397,112	-$387,393	-$379,775	-$418,831	-$408,581	-$400,537
Difference in User Fees	-$1,064,871	-$1,087,212	-$1,090,065	-$1,067,153	-$1,089,468	-$1,092,457
Difference in Insurer Fees	-$1,183,616	-$1,192,065	-$1,191,992	-$1,186,446	-$1,194,838	-$1,194,892
Estimated Net Federal Savings	**$31,816,345**	**$32,866,704**	**$33,312,665**	**$31,857,135**	**$32,907,853**	**$33,359,779**

Appendix D

Results for 5-Year and 10-Year Windows

Tables 17, 18 and 19 show various information over the 10-year deficit period, as required under the CMS checklist.

Table 17: Second Lowest Cost Silver Plan Premium PMPM, with and without Reinsurance, by Rating Area and Year

Rating Area	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Baseline											
1	$244	$296	$309	$321	$337	$354	$371	$389	$408	$428	$449
2	244	300	313	326	342	359	377	395	414	434	456
3	244	300	313	326	342	359	377	395	414	434	456
4	298	369	385	401	420	441	463	486	509	534	560
5	244	300	313	326	342	359	377	395	414	434	456
6	244	300	313	326	342	359	377	395	414	434	456
7	283	369	385	401	420	441	463	486	509	534	560
After Reinsurance											
1		$274	$287	$301	$315	$331	$347	$365	$382	$401	$420
2		278	292	305	320	336	353	370	388	407	426
3		278	292	305	320	336	353	370	388	407	426
4		341	358	375	393	413	433	455	476	500	524
5		278	292	305	320	336	353	370	388	407	426
6		278	292	305	320	336	353	370	388	407	426
7		341	358	375	393	413	433	454	476	499	524

Table 18: Projected Enrollment by FPL, with and without Reinsurance, by Year

	2017	2018	2019	2020	2021	2022
Baseline						
Total Non-Group Enrollment	207,060	200,793	200,793	200,793	200,793	200,793
Total Non-Group APTC Eligible	93,322	93,322	93,322	93,322	93,322	93,322
<100% of FPL	2,037	2,007	2,007	2,007	2,007	2,007
≥100% to ≤150% of FPL	9,756	9,614	9,614	9,614	9,614	9,614
>150% to ≤200% of FPL	30,136	29,697	29,697	29,697	29,697	29,697
>200% to ≤250% of FPL	23,308	22,968	22,968	22,968	22,968	22,968
>250% to ≤300% of FPL	15,877	15,645	15,645	15,645	15,645	15,645
>300% to ≤400% of FPL	20,735	20,433	20,433	20,433	20,433	20,433
>400% of FPL	105,211	100,429	100,429	100,429	100,429	100,429
After Reinsurance						
Total Non-Group Enrollment	207,060	204,162	203,924	203,666	203,666	203,666
Total Non-Group APTC Eligible	93,322	93,322	93,322	93,322	93,322	93,322
<100% of FPL	2,037	2,007	2,007	2,007	2,007	2,007
≥100% to ≤150% of FPL	9,756	9,614	9,614	9,614	9,614	9,614
>150% to ≤200% of FPL	30,136	29,697	29,697	29,697	29,697	29,697
>200% to ≤250% of FPL	23,308	22,968	22,968	22,968	22,968	22,968
>250% to ≤300% of FPL	15,877	15,645	15,645	15,645	15,645	15,645
>300% to ≤400% of FPL	20,735	20,433	20,433	20,433	20,433	20,433
>400% of FPL	105,211	103,797	103,560	103,302	103,302	103,302

Table 19: Projected Enrollment by Metal Level with and without Reinsurance, by Year

	2017	2018	2019	2020	2021	2022
Baseline						
Total Non-Group Enrollment	207,060	200,793	200,793	200,793	200,793	200,793
Catastrophic	897	870	870	870	870	870
Bronze	65,571	63,587	63,587	63,587	63,587	63,587
Silver	114,196	110,740	110,740	110,740	110,740	110,740
Gold	26,395	25,596	25,596	25,596	25,596	25,596
Platinum	-	-	-	-	-	-
After Reinsurance						
Total Non-Group Enrollment	207,060	204,162	203,924	203,666	203,666	203,666
Catastrophic	897	868	867	867	867	867
Bronze	65,571	64,979	64,903	64,903	64,903	64,903
Silver	114,196	112,496	112,365	112,365	112,365	112,365
Gold	26,395	25,819	25,789	25,789	25,789	25,789
Platinum	-	-	-	-	-	-

Appendix E

Reliances and Caveats

The following is a list of the data Wakely relied on for the analysis:

- Wakely collected a complete set of 2016 EDGE Server XML data from each individual market carrier except one carrier who was a negligible portion of the market. The carrier had fewer than 50 members on the 2016 individual market (or approximately 0.02% of the market). The exclusion of the carrier's data is not expected to impact results.

  This data collected from the other 2016 individual market carriers includes

  - The inbound enrollment, medical, pharmacy, and supplement files that were submitted by each carrier to the EDGE Server.
  - The corresponding response files that apply an accept/reject status to the claims in the inbound files.
  - The final outbound files that were produced in May 2016. These files include the risk adjustment, reinsurance, and enrollee claims detail/enrollee claims summary reports.

- Similar 2015 EDGE data from the carriers was used at a high level to test for reasonability of the 2016 data given the possibility that the Co-op closing mid-2016 could cause 2016 to have data anomalies.
- Member-level Co-op enrollment data indicating each member's enrollment within the Co-op and their enrollment within a new plan after the termination of the Co-op. This data was provided by Oregon.
- CMS reports (2016 Final Open Enrollment Report, 2016 March Effectuated Enrollment Report, 2017 Plan and Premium Report, 2017 Final Open Enrollment Report).
- Oregon's quarterly Department of Financial Regulation Enrollment reports, which was provided by Oregon.[24]
- Oregon's CY 2017 effectuated enrollment, April 2017 billing report, where was provided by Oregon.
- 2018 draft carrier rate filings as of July 3rd 2017, Unified Rate Review Templates (URRTs), and other related public information.

[24] http://dfr.oregon.gov/business/report-data/Pages/health-ins-enroll.aspx

Wakely made some assumptions in working with the available data. These assumptions may impact the results of the analyses and were reviewed by Oregon for reasonability.

Enrollment, medical, pharmacy, and supplemental records that were rejected by the EDGE server were removed from the analyses. Wakely utilizes independent logic per the guidance of the EDGE Server Business Rules to identify records that are accepted but not valid for use in the EDGE Server. Medical, pharmacy, and supplemental records that were orphaned, voided, or replaced were removed from the analyses.

The majority of the enrollment (including premiums) and paid claim information provided in the EDGE Server data appeared to be accurate and complete. However, one of the carriers indicated that there was an error in the submission of their 2016 individual market EDGE data that resulted in some membership not being included. The excluded membership accounts for approximately 1.3% of member months in the 2016 individual market. Wakely's understanding is that the premium and claim amounts are also excluded for these enrollees. The exclusion of these enrollees is anticipated to have a negligible impact. Any additional errors in the EDGE server data or other source data could have an impact on the results of these analyses.

Any impact due to private commercial reinsurance was not reflected in the analyses.

The following are additional reliances and caveats that could have an impact on results:

- Political Uncertainty. There is significant policy uncertainty. Future federal actions in regards to mandate enforcement or CSR payment could dramatically change premiums and enrollment in 2018 or future years. Other changes, such as a shorter open enrollment period, introduction of SEP verification, and other regulatory changes could influence enrollment and morbidity.
- Additional Rate Filings Adjustments. Final 2018 rates have not been determined. Any change to current rate filings in the form of premium changes or issuer participation may change premium, claims, or enrollment projections.
- Enrollment Uncertainty. Additionally there is enrollment uncertainty. Beyond changes to potential rates and policy, individual enrollee responses to these changes also has uncertainty. All of these uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.
- Reinsurance Operations. The EDGE data did not perfectly align with the data as reported in the issuer's rate filings. Wakely was able to work with Oregon to identify reasons for the largest discrepancies, and any remaining discrepancies between the EDGE data and the data reported in the issuer's rate filings are not expected to materially impact results. However, there could be

underlying differences that were not discovered during Wakely's review of the data, which may impact the results.

In addition, the EDGE data is currently being used without adjustment to calculate the reinsurance parameters. If actual operations of the reinsurance program differ from the EDGE data configurations, Wakely's analysis would need to be adjusted to match actual reinsurance data requirements. For example, if the reinsurance program includes claims with discharge dates in 2019, Wakely's results may currently underestimate reinsurance payments. Conversely, if the reinsurance program excludes claims with start dates before 2018, Wakely's current process may be overestimating the reinsurance payments. Changes to assumed data requirements, actual data requirements, and data submission quality for reinsurance operations may impact the results.

Appendix F

Disclosures and Limitations

Responsible Actuary. Julie Peper and Danielle Hilson are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the management of Oregon. Wakely understands that the report will be made public and used in the 1332 waiver process. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results. This information is proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Oregon will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of Oregon.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the 'Data and Methodology' and 'Reliances and Caveats' sections identifies the key data and assumptions.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. In addition, many of the assumptions are based on the current status of the carrier rate filings, which are not final. Change in the carrier assumption as well as emerging 2017 enrollment and experience could impact the results. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

79th OREGON LEGISLATIVE ASSEMBLY--2017 Regular Session

Enrolled
House Bill 2391

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of House Interim Committee on Health Care)

CHAPTER .....

AN ACT

Relating to access to health care; creating new provisions; amending ORS 291.055, 731.292, 731.509 and 731.840 and sections 1, 2, 3, 5, 7, 9, 10, 12, 13 and 14, chapter 736, Oregon Laws 2003, and section 2, chapter 26, Oregon Laws 2016; repealing section 15, chapter 389, Oregon Laws 2015; prescribing an effective date; and providing for revenue raising that requires approval by a three-fifths majority.

Be It Enacted by the People of the State of Oregon:

HEALTH INSURANCE PREMIUM AND MANAGED CARE ASSESSMENT

SECTION 1. Sections 2 to 8 of this 2017 Act are added to and made a part of the Insurance Code.

SECTION 2. (1) The Health System Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Health System Fund shall be credited to the fund.

(2) Amounts in the Health System Fund are continuously appropriated to the Department of Consumer and Business Services for the purposes of:

(a) Administering the Oregon Reinsurance Program established in section 18 of this 2017 Act; and

(b) Transferring moneys to the Oregon Health Authority to:

(A) Provide medical assistance and other health services under ORS chapter 414.

(B) Pay refunds due under section 11 of this 2017 Act.

(C) Pay administrative costs incurred by the authority to administer the assessment described in section 9 of this 2017 Act.

SECTION 3. (1) As used in this section:

(a) "Insured" means an eligible employee or family member, as defined in ORS 243.105, who is enrolled in a self-insured health benefit plan under ORS 243.105 to 243.285.

(b) "Premium equivalent" means a claim for reimbursement of the cost of a health care item or service provided to an eligible employee or family member, other than a dental or vision care item or service, and the administrative costs associated with the claim.

(2) No later than 45 days following the end of a calendar quarter, the Public Employees' Benefit Board shall pay an assessment at the rate of 1.5 percent on the gross amount of premium equivalents received during the calendar quarter.

(3) The assessment shall be paid to the Department of Consumer and Business Services and shall be accompanied by a verified report, on a form prescribed by the department, together with any information required by the department.

(4) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on the board.

(5) If the department determines that the assessment paid by the board under this section is incorrect, the department shall charge or credit to the board the difference between the correct amount of the assessment and the amount paid by the board.

(6) The board is entitled to notice and an opportunity for a contested case hearing under ORS chapter 183 to contest an action of the department taken pursuant to subsection (5) of this section.

(7) Moneys received by the department under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act.

SECTION 4. Section 3 of this 2017 Act applies to premium equivalents received by the Public Employees' Benefit Board, or a third party administrator that contracts with the board to administer a self-insured health benefit plan, during the period from January 1, 2018, through December 31, 2019.

SECTION 5. (1) As used in this section:

(a) "Gross amount of premiums" has the meaning given that term in ORS 731.808.

(b) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(2) No later than 45 days following the end of a calendar quarter, an insurer shall pay an assessment at the rate of 1.5 percent of the gross amount of premiums earned by the insurer during that calendar quarter that were derived from health benefit plans delivered or issued for delivery in Oregon.

(3) The assessment shall be paid to the Department of Consumer and Business Services and shall be accompanied by a verified form prescribed by the department together with any information required by the department, that reports:

(a) All health benefit plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid; and

(b) The gross amount of premiums by line of insurance, derived by the insurer from all health benefit plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid.

(4) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on an insurer.

(5) Any rate filed for the department's approval may include amounts paid by the insurer under this section as a valid element of administrative expense or retention.

(6) Moneys received by the department under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act.

SECTION 6. (1) If the Public Employees' Benefit Board or an insurer fails to timely file a verified form or to pay an assessment required under section 3 or 5 of this 2017 Act, the Department of Consumer and Business Services shall impose a penalty on the board or insurer of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.

(2) Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under sections 3 and 5 of this 2017 Act.

SECTION 7. (1) If the Department of Consumer and Business Services determines that the assessment paid by the insurer under section 5 of this 2017 Act is incorrect, the department shall charge or credit to the insurer the difference between the correct amount of the assessment and the amount paid by the insurer.

(2) An insurer that is aggrieved by an action of the department taken pursuant to subsection (1) of this section shall be entitled to notice and an opportunity for a contested case hearing under ORS chapter 183.

SECTION 8. (1) Section 5 of this 2017 Act applies to premiums earned by an insurer for a period of eight calendar quarters beginning on the date, on or after January 1, 2018, that the policy or certificate for which the premiums are paid is issued or renewed.

(2) Notwithstanding any provision of contract or statute, including ORS 743B.013 and 743.022, insurers may increase their premium rate on policies or certificates that are subject to the assessment under section 5 of this 2017 Act by 1.5 percent. If an insurer increases its rates under this subsection, the insurer may include in its billings for health benefit plans a notice, as prescribed by the Department of Consumer and Business Services, explaining that the increase is due to the assessment under section 5 of this 2017 Act.

SECTION 9. (1) As used in this section and sections 10 and 11 of this 2017 Act:

(a) "Managed care organization" means:

(A) A coordinated care organization as defined in ORS 414.025; and

(B) A prepaid managed care health services organization as defined in ORS 414.025.

(b) "Premium equivalent" means the payments made to the managed care organization by the Oregon Health Authority for providing health services under ORS chapter 414.

(2) No later than 45 days following the end of a calendar quarter, a managed care organization shall pay an assessment at a rate of 1.5 percent of the gross amount of premium equivalents received during that calendar quarter.

(3) The assessment shall be paid to the authority in a manner and form prescribed by the authority.

(4) Assessments received by the authority under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act.

(5) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on a managed care organization.

SECTION 10. (1) If a managed care organization fails to timely pay an assessment under section 9 of this 2017 Act, the Oregon Health Authority shall impose a penalty on the managed care organization of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.

(2) Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under section 9 of this 2017 Act.

(3) Penalties received by the authority under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act.

SECTION 11. (1) A managed care organization that has paid an amount that is not required under section 9 of this 2017 Act may file a claim for refund with the Oregon Health Authority.

(2) Any managed care organization that is aggrieved by an action of the authority taken pursuant to subsection (1) of this section shall be entitled to notice and an opportunity for a contested case hearing under ORS chapter 183.

SECTION 12. Sections 9, 10 and 11 of this 2017 Act apply to any payments made to a managed care organization by the Oregon Health Authority for the period beginning January 1, 2018, and ending December 31, 2019.

SECTION 13. ORS 731.292 is amended to read:

731.292. (1) Except as provided in subsections (2)**,** [*and*] (3) **and (4)** of this section, all fees, charges and other moneys received by the Department of Consumer and Business Services or the Director of the Department of Consumer and Business Services under the Insurance Code shall be

deposited in the fund created by ORS 705.145 and are continuously appropriated to the department for the payment of the expenses of the department in carrying out the Insurance Code.

(2) All taxes and penalties paid pursuant to the Insurance Code shall be paid to the director and after deductions of refunds shall be paid by the director to the State Treasurer, at the end of every calendar month or more often in the director's discretion, for deposit in the General Fund to become available for general governmental expenses.

(3) All premium taxes received by the director pursuant to ORS 731.820 shall be paid by the director to the State Treasurer for deposit in the State Fire Marshal Fund.

(4) Assessments received by the department under sections 3 and 5 of this 2017 Act and penalties received by the department under section 6 of this 2017 Act shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act.

SECTION 14. ORS 731.840 is amended to read:

731.840. (1) The retaliatory tax imposed upon a foreign or alien insurer under ORS 731.854 and 731.859, or the corporate excise tax imposed upon a foreign or alien insurer under ORS chapter 317, is in lieu of all other state taxes upon premiums, taxes upon income, franchise or other taxes measured by income that might otherwise be imposed upon the foreign or alien insurer except the fire insurance premiums tax imposed under ORS 731.820**,** [*and*] the tax imposed upon wet marine and transportation insurers under ORS 731.824 and 731.828 **and the assessment imposed under section 5 of this 2017 Act**. However, all real and personal property, if any, of the insurer shall be listed, assessed and taxed the same as real and personal property of like character of noninsurers. Nothing in this subsection shall be construed to preclude the imposition of the assessments imposed under ORS 656.612 upon a foreign or alien insurer.

(2) Subsection (1) of this section applies to a reciprocal insurer and its attorney in its capacity as such.

(3) Subsection (1) of this section applies to foreign or alien title insurers and to foreign or alien wet marine and transportation insurers issuing policies and subject to taxes referred to in ORS 731.824 and 731.828.

(4) The State of Oregon hereby preempts the field of regulating or of imposing excise, privilege, franchise, income, license, permit, registration, and similar taxes, licenses and fees upon insurers and their insurance producers and other representatives as such, and:

(a) No county, city, district, or other political subdivision or agency in this state shall so regulate, or shall levy upon insurers, or upon their insurance producers and representatives as such, any such tax, license or fee; except that whenever a county, city, district or other political subdivision levies or imposes generally on a nondiscriminatory basis throughout the jurisdiction of the taxing authority a payroll, excise or income tax, as otherwise provided by law, such tax may be levied or imposed upon domestic insurers; and

(b) No county, city, district, political subdivision or agency in this state shall require of any insurer, insurance producer or representative, duly authorized or licensed as such under the Insurance Code, any additional authorization, license, or permit of any kind for conducting therein transactions otherwise lawful under the authority or license granted under this code.

SECTION 15. ORS 291.055 is amended to read:

291.055. (1) Notwithstanding any other law that grants to a state agency the authority to establish fees, all new state agency fees or fee increases adopted during the period beginning on the date of adjournment sine die of a regular session of the Legislative Assembly and ending on the date of adjournment sine die of the next regular session of the Legislative Assembly:

(a) Are not effective for agencies in the executive department of government unless approved in writing by the Director of the Oregon Department of Administrative Services;

(b) Are not effective for agencies in the judicial department of government unless approved in writing by the Chief Justice of the Supreme Court;

(c) Are not effective for agencies in the legislative department of government unless approved in writing by the President of the Senate and the Speaker of the House of Representatives;

(d) Shall be reported by the state agency to the Oregon Department of Administrative Services within 10 days of their adoption; and

(e) Are rescinded on adjournment sine die of the next regular session of the Legislative Assembly as described in this subsection, unless otherwise authorized by enabling legislation setting forth the approved fees.

(2) This section does not apply to:

(a) Any tuition or fees charged by a public university listed in ORS 352.002.

(b) Taxes or other payments made or collected from employers for unemployment insurance required by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

(A) Health care services provided by the Oregon Health and Science University, by the Oregon Veterans' Homes and by other state agencies and institutions pursuant to ORS 179.610 to 179.770.

(B) Assessments imposed by the Oregon Medical Insurance Pool Board under section 2, chapter 698, Oregon Laws 2013.

(C) Copayments and premiums paid to the Oregon medical assistance program.

(D) Assessments paid to the Department of Consumer and Business Services under sections 3 and 5 of this 2017 Act.

(d) Fees created or authorized by statute that have no established rate or amount but are calculated for each separate instance for each fee payer and are based on actual cost of services provided.

(e) State agency charges on employees for benefits and services.

(f) Any intergovernmental charges.

(g) Forest protection district assessment rates established by ORS 477.210 to 477.265 and the Oregon Forest Land Protection Fund fees established by ORS 477.760.

(h) State Department of Energy assessments required by ORS 469.421 (8) and 469.681.

(i) Assessments on premiums charged by the Department of Consumer and Business Services pursuant to ORS 731.804 or fees charged by the Division of Finance and Corporate Securities of the Department of Consumer and Business Services to banks, trusts and credit unions pursuant to ORS 706.530 and 723.114.

(j) Public Utility Commission operating assessments required by ORS 756.310 or charges paid to the Residential Service Protection Fund required by chapter 290, Oregon Laws 1987.

(k) Fees charged by the Housing and Community Services Department for intellectual property pursuant to ORS 456.562.

(L) New or increased fees that are anticipated in the legislative budgeting process for an agency, revenues from which are included, explicitly or implicitly, in the legislatively adopted budget or the legislatively approved budget for the agency.

(m) Tolls approved by the Oregon Transportation Commission pursuant to ORS 383.004.

(n) Convenience fees as defined in ORS 182.126 and established by the State Chief Information Officer under ORS 182.132 (3) and recommended by the Electronic Government Portal Advisory Board.

(3)(a) Fees temporarily decreased for competitive or promotional reasons or because of unexpected and temporary revenue surpluses may be increased to not more than their prior level without compliance with subsection (1) of this section if, at the time the fee is decreased, the state agency specifies the following:

(A) The reason for the fee decrease; and

(B) The conditions under which the fee will be increased to not more than its prior level.

(b) Fees that are decreased for reasons other than those described in paragraph (a) of this subsection may not be subsequently increased except as allowed by ORS 291.050 to 291.060 and 294.160.

SECTION 16. ORS 291.055, as amended by section 36, chapter 698, Oregon Laws 2013, section 20, chapter 70, Oregon Laws 2015, and section 44b, chapter 807, Oregon Laws 2015, is amended to read:

291.055. (1) Notwithstanding any other law that grants to a state agency the authority to establish fees, all new state agency fees or fee increases adopted during the period beginning on the date of adjournment sine die of a regular session of the Legislative Assembly and ending on the date of adjournment sine die of the next regular session of the Legislative Assembly:

(a) Are not effective for agencies in the executive department of government unless approved in writing by the Director of the Oregon Department of Administrative Services;

(b) Are not effective for agencies in the judicial department of government unless approved in writing by the Chief Justice of the Supreme Court;

(c) Are not effective for agencies in the legislative department of government unless approved in writing by the President of the Senate and the Speaker of the House of Representatives;

(d) Shall be reported by the state agency to the Oregon Department of Administrative Services within 10 days of their adoption; and

(e) Are rescinded on adjournment sine die of the next regular session of the Legislative Assembly as described in this subsection, unless otherwise authorized by enabling legislation setting forth the approved fees.

(2) This section does not apply to:

(a) Any tuition or fees charged by a public university listed in ORS 352.002.

(b) Taxes or other payments made or collected from employers for unemployment insurance required by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

(A) Health care services provided by the Oregon Health and Science University, by the Oregon Veterans' Homes and by other state agencies and institutions pursuant to ORS 179.610 to 179.770.

(B) Copayments and premiums paid to the Oregon medical assistance program.

(C) Assessments paid to the Department of Consumer and Business Services under sections 3 and 5 of this 2017 Act.

(d) Fees created or authorized by statute that have no established rate or amount but are calculated for each separate instance for each fee payer and are based on actual cost of services provided.

(e) State agency charges on employees for benefits and services.

(f) Any intergovernmental charges.

(g) Forest protection district assessment rates established by ORS 477.210 to 477.265 and the Oregon Forest Land Protection Fund fees established by ORS 477.760.

(h) State Department of Energy assessments required by ORS 469.421 (8) and 469.681.

(i) Assessments on premiums charged by the Department of Consumer and Business Services pursuant to ORS 731.804 or fees charged by the Division of Finance and Corporate Securities of the Department of Consumer and Business Services to banks, trusts and credit unions pursuant to ORS 706.530 and 723.114.

(j) Public Utility Commission operating assessments required by ORS 756.310 or charges paid to the Residential Service Protection Fund required by chapter 290, Oregon Laws 1987.

(k) Fees charged by the Housing and Community Services Department for intellectual property pursuant to ORS 456.562.

(L) New or increased fees that are anticipated in the legislative budgeting process for an agency, revenues from which are included, explicitly or implicitly, in the legislatively adopted budget or the legislatively approved budget for the agency.

(m) Tolls approved by the Oregon Transportation Commission pursuant to ORS 383.004.

(n) Convenience fees as defined in ORS 182.126 and established by the State Chief Information Officer under ORS 182.132 (3) and recommended by the Electronic Government Portal Advisory Board.

(3)(a) Fees temporarily decreased for competitive or promotional reasons or because of unexpected and temporary revenue surpluses may be increased to not more than their prior level without compliance with subsection (1) of this section if, at the time the fee is decreased, the state agency specifies the following:

(A) The reason for the fee decrease; and

(B) The conditions under which the fee will be increased to not more than its prior level.

(b) Fees that are decreased for reasons other than those described in paragraph (a) of this subsection may not be subsequently increased except as allowed by ORS 291.050 to 291.060 and 294.160.

OREGON REINSURANCE PROGRAM

SECTION 17. Sections 18 to 21 of this 2017 Act are added to and made a part of the Insurance Code.

SECTION 18. The Oregon Reinsurance Program is established in the Department of Consumer and Business Services for the purposes of stabilizing the rates and premiums for individual health benefit plans and providing greater financial certainty to consumers of health insurance in this state.

SECTION 19. (1) As used in this section:

(a) "Attachment point" means the threshold dollar amount, adopted by the Department of Consumer and Business Services by rule, for claims costs incurred by a reinsurance eligible health benefit plan for an insured individual's covered benefits in a benefit year, after which threshold the claims costs for the benefits are eligible for reinsurance payments.

(b) "Coinsurance rate" means the rate, adopted by the department by rule, at which the department will reimburse a reinsurance eligible health benefit plan for claims costs incurred for an insured individual's covered benefits in a benefit year after the attachment point and before the reinsurance cap.

(c) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(d) "Reinsurance cap" means the threshold dollar amount, adopted by the department by rule, for claims costs incurred by a reinsurance eligible health benefit plan for an insured individual's covered benefits in a benefit year, after which threshold the claims costs for the benefits are no longer eligible for state reinsurance payments.

(e) "Reinsurance eligible health benefit plan" means a health benefit plan providing individual coverage that:

(A) Is delivered or issued for delivery in this state; and

(B) Is not a grandfathered health plan as defined in ORS 743B.005.

(f) "Reinsurance eligible individual" means an individual who is insured in a reinsurance eligible health benefit plan on or after January 1, 2018.

(2) An issuer of a reinsurance eligible health benefit plan becomes eligible for a reinsurance payment when the claims costs for a reinsurance eligible individual's covered benefits in a calendar year exceed the attachment point. The amount of the payment shall be the product of the coinsurance rate and the issuer's claims costs for the reinsurance eligible individual that exceed the attachment point, up to the reinsurance cap.

(3) After the department adopts by rule the attachment point, reinsurance cap or coinsurance rate, the department may not:

(a) Change the attachment point or the reinsurance cap during that benefit year; or

(b) Increase the coinsurance rate during the benefit year.

(4) The department may adopt rules necessary to carry out the provisions of this section including, but not limited to, rules prescribing:

(a) The amount, manner and frequency of reinsurance payments; and

(b) Reporting requirements for issuers of reinsurance eligible health benefit plans.

SECTION 20. (1) As used in this section:

(a) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(b) "Oregon Reinsurance Program" means the program established in section 18 of this 2017 Act.

(c) "Reinsurance eligible individual" has the meaning given that term in section 19 of this 2017 Act.

(2) An insurer that offers a health benefit plan must report to the Department of Consumer and Business Services, in the form and manner prescribed by the department by rule, information about reinsurance eligible individuals insured by the health benefit plan as necessary for the department to calculate reinsurance payments under the Oregon Reinsurance Program.

SECTION 21. In a rate filing under ORS 743.018, an insurer must identify the impact of reinsurance payments under section 19 of this 2017 Act on projected claims costs and in the development of rates.

SECTION 22. The Oregon Reinsurance Program established in section 18 of this 2017 Act shall be exempt from any and all taxes assessed by the State of Oregon.

SECTION 23. ORS 731.509, as amended by section 35, chapter 698, Oregon Laws 2013, is amended to read:

731.509. (1) The purpose of ORS 731.509, 731.510, 731.511, 731.512 and 731.516 is to protect the interests of insureds, claimants, ceding insurers, assuming insurers and the public generally. The Legislative Assembly declares that its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislative Assembly mandates that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations in accordance with ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurers. The Legislative Assembly declares that the laws contained in ORS 731.509, 731.510, 731.511, 731.512 and 731.516 are fundamental to the business of insurance in accordance with 15 U.S.C. 1011 and 1012.

(2) The Director of the Department of Consumer and Business Services shall not allow credit for reinsurance to a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded unless credit is allowed as provided under ORS 731.508 and unless the reinsurer meets the requirements of:

(a) Subsection (3) of this section;

(b) Subsection (4) of this section;

(c) Subsections (5) and (8) of this section;

(d) Subsections (6) and (8) of this section; [*or*]

(e) Subsection (7) of this section[.]**; or**

(f) Subsection (9) of this section.

(3) Credit shall be allowed when the reinsurance is ceded to an authorized assuming insurer that accepts reinsurance of risks, and retains risk thereon within such limits, as the assuming insurer is otherwise authorized to insure in this state as provided in ORS 731.508.

(4) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state as provided in ORS 731.511. The director shall not allow credit to a domestic ceding insurer if the accreditation of the assuming insurer has been revoked by the director after notice and opportunity for hearing.

(5) Credit shall be allowed when the reinsurance is ceded to a foreign assuming insurer or a United States branch of an alien assuming insurer meeting all of the following requirements:

(a) The foreign assuming insurer must be domiciled in a state employing standards regarding credit for reinsurance that equal or exceed the standards applicable under this section. The United States branch of an alien assuming insurer must be entered through a state employing such standards.

(b) The foreign assuming insurer or United States branch of an alien assuming insurer must maintain a combined capital and surplus in an amount not less than $20,000,000. The requirement of this paragraph does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(c) The foreign assuming insurer or United States branch of an alien assuming insurer must submit to the authority of the director to examine its books and records.

(6) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund meeting the requirements of this subsection and additionally complies with other requirements of this subsection. The trust fund must be maintained in a qualified United States financial institution, as defined in ORS 731.510 (1), for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer must report annually to the director information substantially the same as that required to be reported on the annual statement form by ORS 731.574 by authorized insurers, in order to enable the director to determine the sufficiency of the trust fund. The following requirements apply to such a trust fund:

(a) In the case of a single assuming insurer, the trust fund must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers. In addition, the assuming insurer must maintain a trusteed surplus of not less than $20,000,000.

(b) In the case of a group including incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group.

(B) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the trust shall consist of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States.

(C) In addition to the trusts described in subparagraphs (A) and (B) of this paragraph, the group shall maintain in trust a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(D) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(E) Within 90 days after the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if certification is unavailable, financial statements of each underwriter member of the group prepared by independent certified public accountants.

(c) In the case of a group of incorporated insurers described in this paragraph, the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group. This paragraph applies to a group of incorporated insurers under common administration that complies with the annual reporting requirements contained in this subsection and that has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation. Such a group must have an aggregate policyholders' surplus of $10,000,000,000 and must submit to the authority of this state to ex-

amine its books and records and bear the expense of the examination. The group shall also maintain a joint trusteed surplus of which $100,000,000 must be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities. Each member of the group shall make available to the director an annual certification of the member's solvency by the member's domiciliary regulator and its independent certified public accountant.

(d) The form of the trust and any amendment to the trust shall have been approved by the insurance commissioner of the state in which the trust is domiciled or by the insurance commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(e) The form of the trust and any trust amendments also shall be filed with the insurance commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the director. The trust must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(f) Not later than March 1 of each year, the trustees of each trust shall report to the director in writing the balance of the trust and listing the trust's investments at the preceding year end, and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31.

(7) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection (3), (4), (5) or (6) of this section, but only as to the insurance of risks located in jurisdictions in which the reinsurance is required by applicable law or regulation of that jurisdiction.

(8) If the assuming insurer is not authorized to transact insurance in this state or accredited as a reinsurer in this state, the director shall not allow the credit permitted by subsections (5) and (6) of this section unless the assuming insurer agrees in the reinsurance agreement to the provisions stated in this subsection. This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement. The assuming insurer must agree in the reinsurance agreement:

(a) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(b) To designate the director or a designated attorney as its true and lawful attorney upon whom any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company may be served.

(9) Credit shall be allowed when the reinsurance is ceded to the Oregon Reinsurance Program established in section 18 of this 2017 Act.

[*(9)*] **(10)** If the assuming insurer does not meet the requirements of subsection (3), (4) or (5) of this section, the credit permitted by subsection (6) of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the applicable amount required by subsection (6)(a), (b) or (c) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of the grantor's state or country of domicile, the trustee shall comply with an order of the insurance commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance commissioner with regulatory oversight all the assets of the trust fund.

(b) The assets shall be distributed by and claims shall be filed with and valued by the insurance commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

(c) If the insurance commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the insurance commissioner according to the laws of that state and according to the terms of the trust agreement not inconsistent with the laws of that state.

(d) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this subsection.

SECTION 24. Section 2, chapter 26, Oregon Laws 2016, is amended to read:

Sec. 2. [*(1) Subject to subsection (2) of this section,*] The Department of Consumer and Business Services shall have sole authority to apply for a waiver for state innovation under 42 U.S.C. 18052. [*In developing an application for a waiver, the department shall convene an advisory group to advise and assist the department in identifying federal provisions subject to waiver that are expected to improve the delivery of quality health care to residents of this state including, but not limited to, alternative approaches for achieving the objectives of the Basic Health Program as described in section 1 (4) of this 2016 Act.*] **The department shall apply for a waiver to receive funding to implement the Oregon Reinsurance Program established in section 18 of this 2017 Act.**

[*(2) The department may not submit an application for a waiver to the United States Secretary of Health and Human Services or Secretary of the Treasury until the department has presented the proposed application for a waiver to the committees of the Legislative Assembly related to health and to the Legislative Assembly as specified in subsection (3) of this section.*]

[*(3) Not later than March 1, 2017, the department shall report to the Legislative Assembly, in the manner provided in ORS 192.245, its recommendations for submitting an application for a waiver under 42 U.S.C. 18052.*]

SECTION 25. ORS 731.509, as amended by section 35, chapter 698, Oregon Laws 2013, and section 23 of this 2017 Act, is amended to read:

731.509. (1) The purpose of ORS 731.509, 731.510, 731.511, 731.512 and 731.516 is to protect the interests of insureds, claimants, ceding insurers, assuming insurers and the public generally. The Legislative Assembly declares that its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislative Assembly mandates that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations in accordance with ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurers. The Legislative Assembly declares that the laws contained in ORS 731.509, 731.510, 731.511, 731.512 and 731.516 are fundamental to the business of insurance in accordance with 15 U.S.C. 1011 and 1012.

(2) The Director of the Department of Consumer and Business Services shall not allow credit for reinsurance to a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded unless credit is allowed as provided under ORS 731.508 and unless the reinsurer meets the requirements of:

(a) Subsection (3) of this section;

(b) Subsection (4) of this section;

(c) Subsections (5) and (8) of this section;

(d) Subsections (6) and (8) of this section; **or**

(e) Subsection (7) of this section.[*; or*]

[*(f) Subsection (9) of this section.*]

(3) Credit shall be allowed when the reinsurance is ceded to an authorized assuming insurer that accepts reinsurance of risks, and retains risk thereon within such limits, as the assuming insurer is otherwise authorized to insure in this state as provided in ORS 731.508.

(4) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state as provided in ORS 731.511. The director shall not allow credit to a domestic ceding insurer if the accreditation of the assuming insurer has been revoked by the director after notice and opportunity for hearing.

(5) Credit shall be allowed when the reinsurance is ceded to a foreign assuming insurer or a United States branch of an alien assuming insurer meeting all of the following requirements:

(a) The foreign assuming insurer must be domiciled in a state employing standards regarding credit for reinsurance that equal or exceed the standards applicable under this section. The United States branch of an alien assuming insurer must be entered through a state employing such standards.

(b) The foreign assuming insurer or United States branch of an alien assuming insurer must maintain a combined capital and surplus in an amount not less than $20,000,000. The requirement of this paragraph does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(c) The foreign assuming insurer or United States branch of an alien assuming insurer must submit to the authority of the director to examine its books and records.

(6) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund meeting the requirements of this subsection and additionally complies with other requirements of this subsection. The trust fund must be maintained in a qualified United States financial institution, as defined in ORS 731.510 (1), for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer must report annually to the director information substantially the same as that required to be reported on the annual statement form by ORS 731.574 by authorized insurers, in order to enable the director to determine the sufficiency of the trust fund. The following requirements apply to such a trust fund:

(a) In the case of a single assuming insurer, the trust fund must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers. In addition, the assuming insurer must maintain a trusteed surplus of not less than $20,000,000.

(b) In the case of a group including incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group.

(B) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the trust shall consist of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States.

(C) In addition to the trusts described in subparagraphs (A) and (B) of this paragraph, the group shall maintain in trust a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(D) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(E) Within 90 days after the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if certification is unavailable,

financial statements of each underwriter member of the group prepared by independent certified public accountants.

(c) In the case of a group of incorporated insurers described in this paragraph, the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group. This paragraph applies to a group of incorporated insurers under common administration that complies with the annual reporting requirements contained in this subsection and that has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation. Such a group must have an aggregate policyholders' surplus of $10,000,000,000 and must submit to the authority of this state to examine its books and records and bear the expense of the examination. The group shall also maintain a joint trusteed surplus of which $100,000,000 must be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities. Each member of the group shall make available to the director an annual certification of the member's solvency by the member's domiciliary regulator and its independent certified public accountant.

(d) The form of the trust and any amendment to the trust shall have been approved by the insurance commissioner of the state in which the trust is domiciled or by the insurance commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(e) The form of the trust and any trust amendments also shall be filed with the insurance commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the director. The trust must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(f) Not later than March 1 of each year, the trustees of each trust shall report to the director in writing the balance of the trust and listing the trust's investments at the preceding year end, and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31.

(7) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection (3), (4), (5) or (6) of this section, but only as to the insurance of risks located in jurisdictions in which the reinsurance is required by applicable law or regulation of that jurisdiction.

(8) If the assuming insurer is not authorized to transact insurance in this state or accredited as a reinsurer in this state, the director shall not allow the credit permitted by subsections (5) and (6) of this section unless the assuming insurer agrees in the reinsurance agreement to the provisions stated in this subsection. This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement. The assuming insurer must agree in the reinsurance agreement:

(a) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(b) To designate the director or a designated attorney as its true and lawful attorney upon whom any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company may be served.

[*(9) Credit shall be allowed when the reinsurance is ceded to the Oregon Reinsurance Program established in section 18 of this 2017 Act.*]

[*(10)*] **(9)** If the assuming insurer does not meet the requirements of subsection (3), (4) or (5) of this section, the credit permitted by subsection (6) of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the applicable amount required by subsection (6)(a), (b) or (c) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of the grantor's state or country of domicile, the trustee shall comply with an order of the insurance commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance commissioner with regulatory oversight all the assets of the trust fund.

(b) The assets shall be distributed by and claims shall be filed with and valued by the insurance commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

(c) If the insurance commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the insurance commissioner according to the laws of that state and according to the terms of the trust agreement not inconsistent with the laws of that state.

(d) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this subsection.

HOSPITAL ASSESSMENT

SECTION 26. Section 1, chapter 736, Oregon Laws 2003, as amended by section 34, chapter 792, Oregon Laws 2009, is amended to read:

Sec. 1. As used in sections 1 to 9, chapter 736, Oregon Laws 2003:

(1) "Charity care" means costs for providing inpatient or outpatient care services free of charge or at a reduced charge because of the indigence or lack of health insurance of the patient receiving the care services.

(2) "Contractual adjustments" means the difference between the amounts charged based on the hospital's full established charges and the amount received or due from the payor.

(3)**(a)** "Hospital" [*has the meaning given that term in ORS 442.015*] **means a hospital licensed under ORS chapter 441**.

(b) "Hospital" does not include**:**

(A) Special inpatient care facilities[.]**;**

(B) Hospitals that provide only psychiatric care;

(C) Pediatric specialty hospitals providing care to children at no charge; and

(D) Public hospitals other than hospitals created by health districts under ORS 440.315 to 440.410.

(4) "Net revenue":

(a) Means the total amount of charges for inpatient or outpatient care provided by the hospital to patients, less charity care, bad debts and contractual adjustments;

(b) Does not include revenue derived from sources other than inpatient or outpatient operations, including but not limited to interest and guest meals; and

(c) Does not include any revenue that is taken into account in computing a long term care facility assessment under sections 15 to 22, **24 and 29,** chapter 736, Oregon Laws 2003.

[*(5) "Waivered hospital" means a type A or type B hospital, as described in ORS 442.470, a hospital that provides only psychiatric care or a hospital identified by the Department of Human Services as appropriate for inclusion in the application described in section 4, chapter 736, Oregon Laws 2003.*]

(5) "Type A hospital" has the meaning given that term in ORS 442.470.

(6) "Type B hospital" has the meaning given that term in ORS 442.470.

SECTION 27. Section 2, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 780, Oregon Laws 2007, section 51, chapter 828, Oregon Laws 2009, section 17, chapter 867, Oregon Laws 2009, section 2, chapter 608, Oregon Laws 2013, and section 1, chapter 16, Oregon Laws 2015, is amended to read:

Sec. 2. (1) An assessment is imposed on the net revenue of each hospital in this state that is not a waivered hospital. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate needed to fund the services and costs identified in section 9, chapter 736, Oregon Laws 2003. The rate of assessment shall be imposed on the net revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

(2) In addition to the assessment imposed by subsection (1) of this section, an assessment of 0.7 percent is imposed on the net revenue of each hospital in this state that is not a waivered hospital.

[*(2)*] **(3)** The assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the 75th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection [*(6)*] **(7)** of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

[*(3)(a)*] **(4)(a)** To the extent permitted by federal law, [*aggregate*] assessments imposed under **subsection (1) of** this section may not exceed the **lesser of:**

(A) A rate of 5.3 percent; or

(B) In the aggregate, the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

[*(A)*] **(i)** 30 percent of payments made to the hospitals on a fee-for-service basis by the authority for inpatient hospital services;

[*(B)*] **(ii)** 41 percent of payments made to the hospitals on a fee-for-service basis by the authority for outpatient hospital services; and

[*(C)*] **(iii)** Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed **under subsection (1) of this section** on or after July 1, 2015, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for hospital services under ORS 414.631, 414.651 and 414.688 to 414.745.

[*(4)*] **(5)** Notwithstanding subsection [*(3)*] **(4)** of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

[*(5)*] **(6)** Hospitals operated by the United States Department of Veterans Affairs and pediatric specialty hospitals providing care to children at no charge are exempt from the assessment imposed under this section.

[*(6)(a)*] **(7)(a)** The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, 2019, that will result in the collection occurring between December 15, 2019, and the time all Medicaid cost settlements are finalized for that calendar quarter.

(b) The authority shall prescribe by rule criteria for late payment of assessments.

SECTION 28. Section 2, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 780, Oregon Laws 2007, section 51, chapter 828, Oregon Laws 2009, section 17, chapter 867, Oregon Laws 2009, section 2, chapter 608, Oregon Laws 2013, and section 1, chapter 16, Oregon Laws 2015, and section 27 of this 2017 Act, is amended to read:

Sec. 2. (1) An assessment is imposed on the net revenue of each hospital in this state [*that is not a waivered hospital*]. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate needed to fund the services and costs identified in section 9, chapter 736, Oregon Laws 2003. The rate of assessment shall be imposed on the net revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

(2) In addition to the assessment imposed by subsection (1) of this section, an assessment of 0.7 percent is imposed on the net revenue of each hospital in this state that is not a [*waivered hospital*] **type A hospital or type B hospital**.

(3) [*The*] **Each** assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the [*75th*] **45th** day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection [*(7)*] **(6)** of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

(4)(a) To the extent permitted by federal law, assessments imposed under subsection (1) of this section may not exceed the lesser of:

(A) A rate of 5.3 percent; or

(B) In the aggregate, the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

(i) 30 percent of payments made to the hospitals on a fee-for-service basis by the authority for inpatient hospital services;

(ii) 41 percent of payments made to the hospitals on a fee-for-service basis by the authority for outpatient hospital services; and

(iii) Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed under subsection (1) of this section on or after July 1, 2015, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for hospital services under ORS 414.631, 414.651 and 414.688 to 414.745.

(c) The director may impose a lower rate of assessment on type A hospitals and type B hospitals to take into account the hospitals' financial position.

(5) Notwithstanding subsection (4) of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

[*(6) Hospitals operated by the United States Department of Veterans Affairs and pediatric specialty hospitals providing care to children at no charge are exempt from the assessment imposed under this section.*]

[*(7)(a)*] **(6)(a)** The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, [*2019*] **2021**, that will result in the collection occurring between December 15, [*2019*] **2021**, and the time all Medicaid cost settlements are finalized for that calendar quarter.

(b) The authority shall prescribe by rule criteria for late payment of assessments.

SECTION 29. Section 2, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 780, Oregon Laws 2007, section 51, chapter 828, Oregon Laws 2009, section 17, chapter 867, Oregon Laws 2009, section 2, chapter 608, Oregon Laws 2013, and section 1, chapter 16, Oregon Laws 2015, and sections 27 and 28 of this 2017 Act, is amended to read:

Sec. 2. (1) An assessment is imposed on the net revenue of each hospital in this state. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate needed to fund the services and costs identified

in section 9, chapter 736, Oregon Laws 2003. The rate of assessment shall be imposed on the net revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

[*(2) In addition to the assessment imposed by subsection (1) of this section, an assessment of 0.7 percent is imposed on the net revenue of each hospital in this state that is not a type A hospital or type B hospital.*]

[*(3)*] **(2)** Each assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the 45th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection [*(6)*] **(5)** of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

[*(4)(a)*] **(3)(a)** To the extent permitted by federal law, **aggregate** assessments imposed under [*subsection (1) of*] this section may not exceed [*the lesser of:*]

[*(A) A rate of 5.3 percent; or*

[*(B) In the aggregate,*] the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

[*(i)*] **(A)** 30 percent of payments made to the hospitals on a fee-for-service basis by the authority for inpatient hospital services;

[*(ii)*] **(B)** 41 percent of payments made to the hospitals on a fee-for-service basis by the authority for outpatient hospital services; and

[*(iii)*] **(C)** Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed under [*subsection (1) of*] this section on or after July 1, 2015, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for hospital services under ORS 414.631, 414.651 and 414.688 to 414.745.

(c) The director may impose a lower rate of assessment on type A hospitals and type B hospitals to take into account the hospitals' financial position.

[*(5)*] **(4)** Notwithstanding subsection [*(4)*] **(3)** of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

[*(6)(a)*] **(5)(a)** The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, 2021, that will result in the collection occurring between December 15, 2021, and the time all Medicaid cost settlements are finalized for that calendar quarter.

(b) The authority shall prescribe by rule criteria for late payment of assessments.

SECTION 30. Section 3, chapter 736, Oregon Laws 2003, as amended by section 3, chapter 608, Oregon Laws 2013, is amended to read:

Sec. 3. [*(1)*] Notwithstanding section 2, chapter 736, Oregon Laws 2003, the Director of the Oregon Health Authority shall reduce the rate of assessment imposed under section 2 **(1)**, chapter 736, Oregon Laws 2003, to the maximum rate allowed under federal law if the reduction is required to comply with federal law.

[*(2) If federal law requires a reduction in the rate of assessments, the director shall, after consulting with representatives of the hospitals that are subject to the assessments, first reduce the distribution of moneys described in section 9 (2)(d), chapter 736, Oregon Laws 2003, by a corresponding amount.*]

SECTION 31. Section 5, chapter 736, Oregon Laws 2003, as amended by section 52, chapter 828, Oregon Laws 2009, and section 18, chapter 867, Oregon Laws 2009, is amended to read:

Sec. 5. (1) A hospital that fails to file a report or pay an assessment under section 2, chapter 736, Oregon Laws 2003, by the date the report or payment is due shall be subject to a penalty of

up to $500 per day of delinquency. The total amount of penalties imposed under this section for each reporting period may not exceed five percent of the assessment for the reporting period for which penalties are being imposed.

(2) Penalties imposed under this section shall be collected by the Oregon Health Authority and deposited in the Oregon Health Authority Fund established under [*section 18, chapter 595, Oregon Laws 2009*] **ORS 413.101**.

(3) Penalties paid under this section are in addition to and not in lieu of [*the*] **any** assessment imposed under section 2, chapter 736, Oregon Laws 2003.

SECTION 32. Section 7, chapter 736, Oregon Laws 2003, as amended by section 5, chapter 608, Oregon Laws 2013, is amended to read:

Sec. 7. The Oregon Health Authority may audit the records of any hospital in this state to determine compliance with sections 1 to 9, chapter 736, Oregon Laws 2003[*, and section 1 of this 2013 Act*]. The authority may audit records at any time for a period of five years following the date an assessment is due to be reported and paid under section 2, chapter 736, Oregon Laws 2003.

SECTION 33. Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, section 59, chapter 602, Oregon Laws 2011, and section 7, chapter 608, Oregon Laws 2013, is amended to read:

Sec. 9. (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to [*414.750*] **414.745**, including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to [*414.750*] **414.745**;

(c) Making payments described in section 2 [*(3)(a)(C)*] **(4)(a)(B)(iii)**, chapter 736, Oregon Laws 2003;

(d) Making distributions, as described in section 1 (4) [*of this 2013 Act*]**, chapter 608, Oregon Laws 2013**, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2 **(1)**, chapter 736, Oregon Laws 2003; and

(e) Paying administrative costs incurred by the authority to administer section 1 [*of this 2013 Act*]**, chapter 608, Oregon Laws 2013,** and the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 [*(3)(b)*] **(4)(b)**, chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

SECTION 34. Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, section 59, chapter 602, Oregon Laws 2011, and section 7, chapter 608, Oregon Laws 2013, and section 33 of this 2017 Act, is amended to read:

Sec. 9. (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745, including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745;

(c) Making payments described in section 2 (4)(a)(B)(iii), chapter 736, Oregon Laws 2003;

(d) Making distributions, as described in section 1 (4), chapter 608, Oregon Laws 2013, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2 (1), chapter 736, Oregon Laws 2003; [*and*]

(e) Making payments to coordinated care organizations to be used to provide additional reimbursement to type A hospitals and type B hospitals to improve and expand access to services for medical assistance recipients, to the extent permitted by federal requirements; and

[*(e)*] **(f)** Paying administrative costs incurred by the authority to administer section 1, chapter 608, Oregon Laws 2013, and the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (4)(b), chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

SECTION 35. Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, section 59, chapter 602, Oregon Laws 2011, and section 7, chapter 608, Oregon Laws 2013, and sections 33 and 34 of this 2017 Act, is amended to read:

Sec. 9. (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745 , including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745;

(c) Making payments described in section 2 (4)(a)(B)(iii), chapter 736, Oregon Laws 2003;

[*(d) Making distributions, as described in section 1 (4), chapter 608, Oregon Laws 2013, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2 (1), chapter 736, Oregon Laws 2003;*]

[*(e)*] **(d)** Making payments to coordinated care organizations to be used to provide additional reimbursement to type A hospitals and type B hospitals to improve and expand access to services for medical assistance recipients, to the extent permitted by federal requirements; and

[*(f)*] **(e)** Paying administrative costs incurred by the authority to administer [*section 1, chapter 608, Oregon Laws 2013, and*] the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (4)(b), chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

SECTION 36. Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, section 59, chapter 602, Oregon Laws 2011, and section 7, chapter 608, Oregon Laws 2013, and sections 33, 34 and 35 of this 2017 Act, is amended to read:

Sec. 9. (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745 , including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745;

(c) Making payments described in section 2 [*(4)(a)(B)(iii)*] **(3)(a)(C)**, chapter 736, Oregon Laws 2003;

(d) Making payments to coordinated care organizations to be used to provide additional reimbursement to type A hospitals and type B hospitals to improve and expand access to services for medical assistance recipients, to the extent permitted by federal requirements; and

(e) Paying administrative costs incurred by the authority to administer the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 [*(4)(b)*] **(3)(b)**, chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

SECTION 37. Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, section 59, chapter 602, Oregon Laws 2011, and section 7, chapter 608, Oregon Laws 2013, and section 33 of this 2017 Act, is amended to read:

Sec. 9. (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745, including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745; **and**

(c) Making payments described in section 2 (4)(a)(B)(iii), chapter 736, Oregon Laws 2003;

[*(d) Making distributions, as described in section 1 (4), chapter 608, Oregon Laws 2013, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2 (1), chapter 736, Oregon Laws 2003; and*]

[*(e)*] **(d)** Paying administrative costs incurred by the authority to administer [*section 1, chapter 608, Oregon Laws 2013, and*] the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (4)(b), chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

SECTION 37a. Section 10, chapter 736, Oregon Laws 2003, as amended by section 3, chapter 780, Oregon Laws 2007, section 20, chapter 867, Oregon Laws 2009, section 8, chapter 608, Oregon Laws 2013, and section 6, chapter 16, Oregon Laws 2015, is amended to read:

Sec. 10. Sections 1 to 9, chapter 736, Oregon Laws 2003, apply to net revenues earned by hospitals during a period beginning October 1, 2015, and ending the earlier of September 30, [*2019*] **2021**, or the date on which the assessment no longer qualifies for federal financial participation under Title XIX or XXI of the Social Security Act.

SECTION 38. Section 12, chapter 736, Oregon Laws 2003, as amended by section 4, chapter 780, Oregon Laws 2007, section 21, chapter 867, Oregon Laws 2009, section 9, chapter 608, Oregon Laws 2013, and section 3, chapter 16, Oregon Laws 2015, is amended to read:

Sec. 12. (1) Sections 1 to 9, chapter 736, Oregon Laws 2003, [*and section 1, chapter 608, Oregon Laws 2013,*] are repealed on January 2, [*2024*] **2026**.

(2) Section 1, chapter 608, Oregon Laws 2013, is repealed on July 1, 2018.

SECTION 39. Section 13, chapter 736, Oregon Laws 2003, as amended by section 5, chapter 780, Oregon Laws 2007, section 22, chapter 867, Oregon Laws 2009, section 10, chapter 608, Oregon Laws 2013, and section 4, chapter 16, Oregon Laws 2015, is amended to read:

Sec. 13. Nothing in the repeal of sections 1 to 9, chapter 736, Oregon Laws 2003, and section 1, chapter 608, Oregon Laws 2013, by section 12, chapter 736, Oregon Laws 2003, affects the imposition and collection of a hospital assessment under sections 1 to 9, chapter 736, Oregon Laws 2003, for a calendar quarter beginning before September 30, [*2019*] **2021**.

SECTION 40. Section 14, chapter 736, Oregon Laws 2003, as amended by section 6, chapter 780, Oregon Laws 2007, section 23, chapter 867, Oregon Laws 2009, and section 5, chapter 16, Oregon Laws 2015, is amended to read:

Sec. 14. Any moneys remaining in the Hospital Quality Assurance Fund on December 31, [*2023*] **2025**, are transferred to the General Fund.

SECTION 41. The Oregon Health Authority shall ensure that the Oregon Health and Science University receives net reimbursement of at least 84 percent but no more than 100 percent of the university's costs of providing services that are paid for, in whole or in part, with Medicaid funds. Net reimbursement means all Medicaid payments less any amount that is transferred by the university to the authority.

FUNDING

SECTION 42. (1) An amount is transferred to the Health System Fund established under section 2 of this 2017 Act from the unexpended balance of the Health Insurance Exchange Fund established under ORS 741.102, that equals the difference between the balance in the Health Insurance Exchange Fund and the projected expenditures from the Health Insurance Exchange Fund during the next six months.

(2) Any unexpended balance of the Oregon Medical Insurance Pool Account established in ORS 735.612 remaining of the effective date of this 2017 Act is transferred to the Health System Fund established under section 2 of this 2017 Act.

(3) The transfers described in subsections (1) and (2) of this section shall be made from moneys maintained, on the effective date of this 2017 Act, in the Health Insurance Exchange Fund and the Oregon Medical Insurance Pool Account.

OPERATIVE DATES, EFFECTIVE DATES, REPEALS AND TECHNICAL ADJUSTMENTS

SECTION 43. Sections 3 to 12 of this 2017 Act and the amendments to ORS 291.055, 731.292 and 731.840 by sections 13 to 16 of this 2017 Act become operative on January 1, 2018.

SECTION 44. (1) If the Centers for Medicare and Medicaid Services permits the state to impose the assessment under section 2, chapter 736, Oregon Laws 2003, on type A hospitals and type B hospitals and to exclude from the assessment public hospitals other than health district hospitals:

(a) Section 41 of this 2017 Act and the amendments to sections 1, 2 and 9, chapter 736, Oregon Laws 2003, by sections 26, 28 and 34 of this 2017 Act become operative on the later of:

(A) January 1, 2018; or

(B) The date of the approval by the Centers for Medicare and Medicaid Services.

(b) The amendments to sections 3, 7 and 9, chapter 736, Oregon Laws 2003, by sections 30, 32 and 35 of this 2017 Act become operative on July 1, 2018.

(c) The amendments to sections 2 and 9, chapter 736, Oregon Laws 2003, by sections 29 and 36 of this 2017 Act become operative on July 1, 2019.

(2) If the Centers for Medicare and Medicare Services denies approval for the state to impose the assessment under section 2, chapter 736, Oregon Laws 2003, on type A hospitals and type B hospitals and to exclude from the assessment public hospitals other than health district hospitals, the amendments to section 9, chapter 736, Oregon Laws 2003, by section 37 of this 2017 Act become operative on July 1, 2018.

(3) The Director of the Oregon Health Authority shall notify the Legislative Counsel upon receipt of an approval or denial by the Centers for Medicare and Medicaid Services of permission to impose the assessment under section 2, chapter 736, Oregon Laws 2003, on type A hospitals and type B hospitals and to exclude from the assessment public hospitals other than health district hospitals.

SECTION 45. (1) Sections 18 to 22 of this 2017 Act and the amendments to ORS 731.509 and section 2, chapter 26, Oregon Laws 2016, by sections 23 and 24 of this 2017 Act become operative on the later of:

(a) The date the United States Department of Health and Human Services approves a waiver for state innovation under 42 U.S.C. 18052 in accordance with section 2, chapter 26, Oregon Laws 2016, as amended by section 24 of this 2017 Act; or

(b) January 1, 2018.

(2) The Director of the Department of Consumer and Business Services shall notify the Legislative Counsel upon receipt of the approval or denial of funding for the Oregon Reinsurance Program under 42 U.S.C. 18052.

SECTION 46. The amendments to ORS 731.509 by section 25 of this 2017 Act become operative on January 2, 2024.

SECTION 47. Section 15, chapter 389, Oregon Laws 2015, is repealed.

SECTION 48. Sections 18 to 22 of this 2017 Act are repealed on January 2, 2024.

SECTION 49. The Department of Consumer and Business Services may take any action before the operative date specified in sections 43 and 45 of this 2017 Act for sections 2 to 12 and 18 to 22 of this 2017 Act and the amendments to ORS 291.055, 731.292, 731.509 and 731.840 and section 2, chapter 26, Oregon Laws 2016, by sections 13 to 16, 23 and 24 of this 2017 Act that is necessary for the department to carry out sections 2 to 12 and 18 to 22 of this 2017 Act and the amendments to ORS 291.055, 731.292, 731.509 and 731.840 and section 2, chapter 26, Oregon Laws 2016, by sections 13 to 16, 23 and 24 of this 2017 Act on the operative date specified in sections 43 and 45 of this 2017 Act.

SECTION 50. The unit captions used in this 2017 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2017 Act.

SECTION 51. This 2017 Act takes effect on the 91st day after the date on which the 2017 regular session of the Seventy-ninth Legislative Assembly adjourns sine die.

Passed by House June 15, 2017

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate June 21, 2017

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2017

Approved:

.....M.,....., 2017

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2017

.....
Dennis Richardson, Secretary of State

BEHRENS Anthony A * DCBS

From: Oregon Department of Consumer and Business Services <ordcbs@public.govdelivery.com>
Sent: Tuesday, July 25, 2017 3:46 PM
To: BEHRENS Anthony A * DCBS
Subject: 1332 Waiver Application for Public Comment

Oregon Health Insurance Marketplace

1332 Waiver Application for Public Comment

About the waiver
The Oregon Department of Consumer and Business Services is applying for a State Innovation Waiver from the federal government, and the public is invited to comment on Oregon's application. The waiver, also known as a 1332 waiver, is an opportunity for states to implement unique programs that help increase access to quality, affordable health insurance for their residents. Federal savings from these changes can be used to fund innovation at the state level.

Oregon intends to use the waiver authority to partially fund the Oregon Reinsurance Program. The reinsurance program, created by Oregon House Bill 2391, will reimburse carriers for high claims and will spread the cost of high-risk individuals more broadly among carriers. Oregon expects these steps will cultivate greater certainty in the market, slow the rise of health insurance premiums, and facilitate insurance companies' continued participation throughout the state in the individual and small-group markets.

How to comment on the application
Download the waiver application here to review it.

You may comment in person or in writing. If you comment in person, you are strongly encouraged to also submit comments in writing.

DCBS has scheduled opportunities for in-person comments on **August 24** and **August 25**:

August 24, 2017
1:00 p.m. to 4:00 p.m.
Labor and Industries Building
Conference Room 260
350 Winter Street NE
Salem

August 25, 2017

Pine Room
421 SW Oak Street
Portland

Written comments are due by August 27. Written comments, whether submitted in addition to or instead of in-person comments, will be accepted through August 27, 2017 at 5:00 p.m. Submit written comments by email to: 1332.comments@oregon.gov.

Oregon Health Insurance Marketplace

1-855-268-3767

info.marketplace@oregon.gov

BEHRENS Anthony A * DCBS

From: Jesse O'Brien <jesseo@ospirg.org>
Sent: Thursday, August 24, 2017 1:11 PM
To: DCBS 1332 Comments * DCBS
Subject: OSPIRG comments in support of Oregon 1332 waiver
Attachments: OSPIRG comments on OR 1332 waiver.pdf

Greetings,

Attached, please find OSPIRG's written comments in support of Oregon's 1332 waiver proposal and the Oregon Reinsurance Program. Thank you for the opportunity to provide comment on this important proposal.

Best,

Jesse Ellis O'Brien
Policy Director
OSPIRG and OSPIRG Foundation
1536 SE 11th Ave, Ste. A
Portland, OR 97214
office: 971-266-2463 | cell: 503-504-8627
www.ospirg.org | jesseo@ospirg.org

OSPIRG
Standing Up To Powerful Interests

1536 SE 11th Ave., Ste. A | Portland, OR 97214
www.ospirg.org (503) 231-4181 (ph)
info@ospirg.org (503) 231-4007 (fx)

To: Oregon Department of Consumer and Business Services

From: Jesse Ellis O'Brien, OSPIRG Policy Director

Date: August 24, 2017

Re: Comment in support of Oregon's proposed 1332 waiver

OSPIRG supports the Oregon Reinsurance Program established by House Bill 2391 (2017) and the state's effort to support this program through an application for a State Innovation Waiver under section 1332 of the Affordable Care Act.

This proposal will help stabilize Oregon health insurance markets and protect consumers from large rate increases, and represents a win for both consumers and the health insurance industry—all at no net cost to the federal government.

Oregon consumers have faced large double-digit rate hikes in the individual health insurance market in both 2016 and 2017. Some health insurers have also gone out of business, left the state or shrunk their service area during this period, leaving many consumers with fewer options and less robustly competitive health insurance markets.

Oregon has already demonstrated the power of a well-designed and well-executed reinsurance program to contain premium costs. Following the passage of HB 2391, a combination of reinsurance and close scrutiny of health insurance rate filings led to big reductions in rates for 2018—cutting over $100 million from premiums, by our estimate.

The Oregon Reinsurance Program is a needed first step toward a stable and sustainable individual health insurance market, but it is only a first step. We also urge the state to take action to address the underlying causes of instability and higher costs in the individual market. These causes include insurance market dynamics such as adverse selection, but they also include the excessive and rising cost of health care services and prescription drugs.

By providing needed immediate relief for consumers, we hope that the Oregon Reinsurance Program will help buy our state and our health care system time to do the hard work necessary to address the underlying drivers of health care costs. This work will be best served by coordinating health insurance rate review, the efforts of Oregon's health insurance exchange, Medicaid Coordinated Care Organizations, public employee plans and other public payers to ensure that incentives are aligned throughout Oregon's health care system with our shared goals of improved care, improved health and reduced cost.

Thank you for the opportunity to provide comment in support of this important proposal.

BEHRENS Anthony A * DCBS

From: Rep Parrish <rep.julieparrish@state.or.us>
Sent: Thursday, August 24, 2017 10:48 AM
To: DCBS 1332 Comments * DCBS
Cc: ALLEN Patrick * DCBS; REP Hayden
Subject: Hayden-Parrish Comments on 1332 Waiver
Attachments: Reps. Hayden-Parrish Joint Comments on Oregon's 1332 Waiver Request.pdf

Importance: High

Patrick,

Please accept this attached public comment for the Oregon 1332 waiver process.

If you could please provide the information for where we can provide comments to CMS next week, that would be appreciated.

Best,

Rep. Parrish

August 24th, 2017

Interim Director Patrick Allen
Oregon Health Authority
2600 Center Street NE
Salem, OR 97301

Dear Interim Director Allen,

The following letter constitutes our concerns about Oregon's application for a 1332 State Innovation Waiver which is currently being sought from the Center for Medicare and Medicaid Services (CMS), a division of the United States Department of Health and Human Services (HHS).

In 2013, the Oregon Legislature created what was to be a temporary reinsurance program while the Oregon Health Exchange (formerly known as Cover Oregon) was ramping up to enroll lives into the Exchange under the Patient Protection and Affordable Care Act (ACA). It was estimated that the reinsurance program would be a temporary measure until such a time that the Exchange was operating at a break-even capacity, some 285,000 lives to be covered. The reinsurance program ended in 2016, leaving a $50 million dollar balance in the program. The Oregon Legislature opted to renew the program, sweeping the $50 million dollar "windfall" back into the program while seeking additional funds to shore up the renewed reinsurance program. As part of that effort, the state was directed through House Bill 2391 to seek this 1332 waiver.

Oregon's waiver draft rightly states the problem our state is having in maintaining a robust insurance market with consumer choices. However, the draft wrongly identifies a reinsurance program as the solution to a volatile insurance market that has left Oregon consumers with dwindling choices both in and out of the Exchange, while simultaneously facing double-digit rate increases. In fact, early in 2017, the Department of Consumer and Business services put forth a document that expressed concerns whether a 1332 waiver was the correct course of action for Oregon and made a recommendation that we NOT pursue a 1332 waiver. We agree with the original recommendation to not pursue a waiver. Indeed, as we see it, the solution to fixing these problems doesn't lie in taxing consumers to subsidize the marketplace with a reinsurance program as a mechanism to decrease rates. We also believe the tax mechanisms proposed by House Bill 2391 are not broad-based enough to even qualify for such a waiver.

The fact is Oregon failed to enroll enough lives into the Exchange to spread the risk pool in such a manner so that the insurance market would stabilize on its own without an additional infusion of state or federal tax dollars. We pinpoint the failure of the Exchange to House Bill 2128 (2013) when the legislature repealed portions of a negotiated compromise in House Bill 4164 (2012), the business plan for the Cover Oregon. In House Bill 4164, Oregon's school districts would have been granted the opportunity to buy insurance for their employees via the Exchange beginning in School Year 2015. Besides an estimated $400 million in annual K-12 budget school savings had House Bill 4164 been implemented, the net result of adding 150,000 lives from school districts, coupled with the existing 135,000 lives currently in the Exchange, would have leveled out risk pool. Subsequently, it would have held down rates for all ratepayers in the Exchange without the need for a costly, taxpayer-funded reinsurance program as proposed by this waiver.

Had we followed through with the policy in House Bill 4164, Oregon would have achieved the 285,000 lives needed to make the Exchange function as originally planned.

We dispute projections of insurance rate decreases estimated by this waiver request will manifest at the levels proposed by the agency. This year, rate requests from the remaining insurers in Oregon ranged upwards to an eye-popping 21%. The state granted rate requests as high a 14% for some carriers, while granting only 2% rate increases for others. These variances have caused some insurers to exit markets, and in rural Oregon, leave ratepayers with only one carrier choice. In subsequent biennia, as these insurers bear the brunt of healthcare costs for some of Oregon's highest risk patients who buy their coverage via the Exchange, without expanding the risk pool itself, we believe it will be impossible to create the kinds of rate savings this waiver purports to potentially yield. The reinsurance program created by the 2013 legislation did little to offset repeated, annual double-digit rate increases or exits from the marketplace. In fact, Moda, because of poor rate planning and the amount of high-risk patients entering the marketplace, required a $50 million dollar loan from Oregon Health Sciences University to stabilize their presence in Oregon.

The projected increase in people buying insurance in the marketplace is not enough to bring the overall risk down. Of concern are the number of people who have bronze and silver plans who are unable to afford associated premiums. Hospitals in Oregon self-report seeing an increase in charity care of people with ACA coverage who cannot afford co-pays associated with these plans. This uptick in charity care occurred with a reinsurance program in place. Given the continued volatility of the insurance marketplace in Oregon, we dispute the cost savings renewing the reinsurance program is purported to save the federal government.

The 1332 waiver request by Oregon to CMS is also predicated on the passage of taxes in House Bill 2391. Currently, there is a referendum effort to repeal the taxes in Sections 3, 5, 9 and 27. Even if voters are not successful in repealing the tax mechanisms in House Bill 2391, we also do not believe that these taxes constitute a broad enough base to even qualify for a 1332 waiver.

The following takes a look at the tax mechanisms the state is looking to use as the basis for its waiver request. These dollars were also warranted as a potential revenue stream for additional Medicaid match dollars from the federal government:

Section 3: This 1.5% tax is on the insurance for Oregon's Public Employee Benefit Board (PEBB). Given healthcare for public workers come from state tax resources, the tax on PEBB plans constitutes a tax on tax dollars. It does not generate net-new revenue for the state from which to constitute a broad-base for a 1332 waiver request or new resources for Medicaid matching.

Section 5: The 1.5% tax on insurance markets will impact about 1.2 million Oregonians who through their own purchasing power or via an employer, will see a rate increase as a result of the tax. Separately, nearly one million Oregonians who receive employer-sponsored benefits via self-insurance will not be subject to this tax. This unfair tax burden being leveraged to generate both a 1332 waiver and potentially Medicaid match dollars, disproportionately impacts just over half of the healthcare-purchasing market while leaving the other half of remaining Oregonians free from taxation. We believe this tax does not meet the requirements for a 1332 waiver.

Section 9: This 1.5% tax on Medicaid Coordinated Care Organizations (CCOs, MCOs) is incredibly problematic. The state currently leverages a Medicaid match from the federal government via hospital and long-term care bed tax assessments. Under Oregon's laws, these dollars are assessed to the hospital or long-term care facility, matched with federal funds, and then redeployed to Medicaid providers. The taxation provision in Section 9 of House Bill 2391 proposes to tax the gross revenues of MCOs for the

purpose of attempting a second bite at a Medicaid match. However a legal opinion from Oregon's legislative counsel states that the taxes in Sections 5 and 9 of House Bill 2391 are essentially fungible to Oregon's General Fund. We find the "double dip" element of the MCO tax to be at odds with the intent of the match programs allowed by CMS for Medicaid, and would not be able to be used as consideration for a 1332 waiver. In fact, we believe that this particular provision in House Bill 2391, if found to be in violation of federal Medicaid policy, has the potential to put our entire Medicaid program as it's currently delivered in jeopardy.

Additionally, the state has presented a timeline for a 1332 waiver which does not align with that tax-raising mechanisms in House Bill 2391 to fund the reinsurance program. Should the taxation components in House Bill 2391 stand up to a referendum of Oregon voters, the bill itself has language that without another vote of the legislature, would render the taxes in the Section 3 PEBB tax and the Section 9 MCO tax sunsetted. This would only leave the taxation of insurance premiums in Section 5 moving forward, which would not constitute a broad enough base for a long-term reinsurance plan as presented to CMS in the request by Oregon for the 1332 waiver.

Waiver requirements specially ask states to demonstrate a 10-year budget showing the waiver will not increase the federal deficit and show how the waiver will not decrease coverage or affordability. We do not believe the state can adequately prove to CMS a 10-year budget plan with a broad enough tax base given two of the tax provisions in House Bill 2391 sunset in 2019, and given nearly half of Oregonians who have private-pay health coverage are not subject to the taxes in House Bill 2391.

Additionally, if the legislature chooses in the next biennium to sunset the tax provisions in Sections 3 and 9, the resulting cost increases demonstrated in Oregon's draft budget to fund the growth of the reinsurance program will disproportionately fall to only one category of insured. The net result will likely manifest in decreased coverage as insurers continue to drop out of the marketplace and increased costs to ratepayers when insurance companies pass additional costs to consumers. We believe this does little to stabilize the market and puts Oregon back in the position of having to negotiate with the federal government for increased budget allocations or additional waiver options to keep citizens covered.

This bait-and-switch type tactic should raise red flags for CMS about the long-term sustainability of the reinsurance program proposed by Oregon. Indeed, as the potential for the PEBB and MCO taxes disappear with a sunset, and the cost of the reinsurance program to the state is slated to rise, we have concerns about the state's ability to fund its share of a reinsurance program long term.

Lastly, we have concerns about future "windfalls" and how funds remaining in the reinsurance program are handled. With the close of the reinsurance program that ended in 2016, the state was left with a $50 million dollar balance that had been generated by ratepayers. We believe keeping those funds and redistributing them back to insurance companies, and not to the ratepayers from whom the funds were generated, violated the public's trust in a state-run reinsurance program. The $50 million overdraw from ratepayers, and the subsequent redistribution to insurance companies proposed by this new reinsurance request, we maintain, amounts to a taking from individuals who may no longer be participating in the insurance marketplace.

We believe the federal government should be concerned as we are by a reinsurance program that lends itself to profiteering by insurance companies at the expense of ratepayers. House Bill 2391 was pitched as a bill that "taxes big insurance companies" yet insurance companies themselves are twice-exempted: once as an employer because they self-insure, and secondarily, because Section 8 of House Bill 2391 gives statutory authority for insurance companies to pass the new taxes directly to ratepayers. If the taxation under House Bill 2391 is passed directly to ratepayers, then a reinsurance program in which a positive fund

balance is created by that taxation should be restored to those who actually incurred the tax liability. House Bill 2391 has no such provision to protect ratepayers.

Interim Director Allen, we understand the responsibility for management of the health and welfare of millions of lives in Oregon is a weight bigger than one agency director, one governor, or 90 legislators can possibly comprehend. However, we've watched mistake after mistake in how Oregon has implemented the components of the Affordable Care Act. From a failed Cover Oregon web portal that wasted over $300 million dollars, to policy decisions that neutered the participation and financial efficacy of the Exchange, to a Medicaid backlog which has cost the state hundreds of millions in additional healthcare IT software challenges, not to mention hundreds of millions in Medicaid overpayments to Coordinated Care Organizations, our handling of the ACA has been ineffective and has cost Oregon taxpayers and the federal government dearly.

We would ask that you go back and revisit your original recommendation that the state NOT participate in a 1332 waiver request. We have much work to do to bring down insurance rates and healthcare costs for Oregonians, but the solution doesn't lie in more costly gimmicks like a reinsurance program. It would stand to reason that taxing healthcare is not the way to make it more affordable. We're further concerned that recent announcements of layoffs and hiring freezes at hospitals across Oregon due to tax increases in House Bill 2391 and hospital payment capping in Senate Bill 1067 (2017) will contribute to a sharp increase in healthcare costs and a decrease in healthcare access for Oregon citizens that this 1332 waiver request won't address.

We would like during your time as interim director of Oregon's Health Authority for you take the opportunity to provide sound policy recommendations to Governor Brown and the legislature for how to implement what we all originally understood would bring down rates long term – and that's getting more lives into the risk pool to stabilize the market. We must revisit moving public employee lives onto the Exchange as a way to boost participation and bring down the overall risk, which in turn, would help bring down insurance rates for ratepayers and reduce pressure on all taxpayers who contribute to the healthcare benefit costs of public employees. Anything else is just a continuation of failed policy decisions which have ruined the chance of cost savings voters were promised with the passage of the Affordable Care Act.

Next year, many Oregonians will forced to change insurance providers and doctors while simultaneously experiencing double digit rate increases. The state should take care to avoid policies that will continue to increase consumer insurance costs for some, while giving tax carve-outs to nearly half of Oregon's healthcare purchasers. What we're doing in Oregon's insurance market is unsustainable.

We appreciate your consideration of our comments on Oregon's request for a 1332 waiver and would urge the state and CMS to avoid this expensive and wrong choice. We believe Oregon's proposal doesn't fit the requirements for a waiver, and that ultimately, a costly reinsurance program will do more harm than good. It's time to come back to the table to find a better path to bring down long-term healthcare costs, and we're ready to work towards that end.

Sincerely,

Rep. Cedric Hayden
Falls Creek

Rep. Julie Parrish
West Linn

BEHRENS Anthony A * DCBS

From: Victoria Bramley <victoria@insurancestores.com>
Sent: Thursday, August 24, 2017 3:24 PM
To: DCBS 1332 Comments * DCBS
Subject: Comment on historical success of public/private partnerships

Hello,

This would be an excellent opportunity to prove what President Kennedy had started with the FEB Federal Executive Board; public and private entities working collaboratively to solve social problems. We so applaud this direction

Strong evidence of some previous successful public and private collaboration success stories:

Medicare when joined with private insurance carriers many many years ago developed the Medicare Supplement plan market only to solve a problem. This enabled the consumer to be able to pay for care expenses through private insurance that was not covered by original Medicare. The program was and still is overseen by the government. This collaboration not only relieved the consumer, but took a massive financial burden off the government, and the tax payer who would have had to pay for the care anyway for the people who could not afford this 'gap'. More people would have eventually shifted onto Medicaid.

And like Medicare Supplements above..these below were offered all year long so no rush to get the masses in a plan change in just 45-60 days.

OMIP Oregon Medical Insurance Pool was a program in Oregon to help those with pre-existing conditions at at time when health underwriting was the only way to get private health insurance. With a partnership between the public and private sectors again this OMIP program helped many gain quality plans and care not available to them beforehand. Although a higher premium....this was often paid for the consumer by FHIAP.

FHIAP Federal Health Insurance Assistance Program. This program, collaboratively managed with carrier support, helped cover the premium cost for those who were on OMIP but could not afford a health insurance plan. These plans were the exact same anybody could choose from. Up to 95% of a consumers premium was paid based on their income sof often someone with limited income chose the top of the line plans offered by all the carriers.

There are others.

I as an agent came into my healthcare planning career like most agents due to personal family healthcare issues. In the mid 1990's after caring for numerous very ill family members and struggling with how to pay for care, while raising my family, I myself witnessed it often came down to who had money for elder care and who didn't. Today not just in elder care but in health care in general for young and old, with today's cost of premiums, and other out of pocket cost, people are now more than ever not going to the doctor. This whole experience of cost of care led me to becoming a health insurance expert.

In my work, health insurance agents in the field, not a carrier agent or government employee or non agent, meet daily with people from all backgrounds in their particular communities and represent all races, ethnicity, religious or not affiliations, and all genders and immigrants or not etc. Field agents are often the first to meet people who are in pain, physically, mentally and or emotionally and financially and seeking help with care.

Agents without pay or compensation often do pro-bono work and refer people to the resources they know will gain them healthcare as quickly as possible such as emergency services, food sources, shelter, low or no cost medical clinics, aging and disability resources, Meals on Wheels, and much more more.

For some time the public and private world in the not too distant past, under the direction of Mark Jungvert and others such as SHIBA, in Oregon historically, recognized that the health insurance independent agent who under a brokerage hierarchy could and did reach more people statewide to provide more care, quickly spreading any new state or fed or carrier program, and save the state, federal government and carrier financially by doing so.

An agent in the field does not cost the state or federal government or even the carrier anything to be the messenger and saves the cost of employee benefits and massive overhead of public or carrier call centers etc. We as agents are ONLY paid if and when we sign a client up for a plan. Agent have a fiduciary responsibility to do the right thing in order to keep their clients happy and thus retain their client. And with the majority of agents welcoming government oversight of agents, agents are trained, experienced, licensed, meet E and O, have multiple annual certifications, take required CE courses, follow strict carrier, state and federal compliance laws, all appreciated and combined to protect the consumer. The result is working collaboratively public and private entities save money while solving our countries problems.

I applaud the move towards working together and the understanding how carriers and states must be able to financially cover the cost of care by doing so. Whether public or private, if not enough money comes in then taxes and or premiums must go up to do so hurting everyone and dividing us even more.

Encouraging state employees, social workers and state volunteers to partner with local professional agencies and visa versa benefits all our communities.

Thank you.

Victoria Bramley
President
Victoria Bramley CLTC CSA
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BEHRENS Anthony A * DCBS

From: SMITH Robert D * DCBS
Sent: Monday, August 07, 2017 10:37 AM
To: 'Allyson Lecatsas'; 'AmberRobertson@coquilletribe.org'; 'anitab@ctsi.nsn.us'; 'brandon.tupper@klm.portland.ihs.gov'; Brenda Bremner; 'carina.miller@wstribes.org'; Carol Prevost; 'Caroline.cruz@wstribes.org'; Chanda Yates; Christina Peters; Cindy Delay; 'Deborah.alvarez@ihs.gov'; Dennis Eberhardt; 'donbjr@ctsi.nsn.us'; George Lopez; Heather Joy Gurko; 'IMontiel@ctclusi.org'; Jackie Mercer; Jacoba Best; Jeremiah Johnson; Jim Wallis; Joe Finkbonner; Judith Adams; 'kellelittle@coquilletribe.org'; 'kelly.rowe@grandronde.org'; Laura Herbison; Laura Platero; 'lena.schonchin@klm.portland.ihs.gov'; Linda Hettinga; Lisa Griggs; Michael Stickler; 'michael.collins@wstribes.org'; Michelle Bradach; 'mwatkins@naranorthwest.org'; Peggy Ollgaard; 'SandraSampson@yellowhawk.org'; Shana Radford; Sonciray Bonnell; 'sstanphill@cowcreek.com'; 'teemantm@burnspaiute-nsn.gov'; Terry Dean; Tim Gilbert; 'tracyl@ctsi.nsn.us'; 'tresa.mercier@grandronde.org'; Trudy Simpson; 'vfaciane@ctclusi.org'
Cc: BEHRENS Anthony A * DCBS; FLOWERS Chiqui L * DCBS; CRONEN Elizabeth M * DCBS
Subject: Tribal Consultation Request: 1332 Waiver Application
Attachments: 1332-consultation letter.pdf; DRAFT Oregon 1332 Waiver Application.pdf

Importance: High

Tribal Partners,

I hope you're all doing well.

Please see the attached documents which provide detail on an upcoming opportunity for Tribal Consultation. The Marketplace will be submitting a waiver to the federal government with the intended result of stabilizing the insurance risk pools and lowering premiums in Oregon.

The details on the opportunity to provide comment in person or over the phone is in the letter, but I'll provide it here as well:

Date: August 25, 2017
Time: 1 p.m. to 3 p.m.
Place: Lincoln Building, in the Pine Room; 421 SW Oak Street; Portland OR 97204
You may also consult via telephone: 712-770-4010, access code 180247

You are also strongly encouraged to also submit written statements to 1332.comments@oregon.gov.

Written statements will be accepted through 5 p.m. on August 27, 2017.

Please reach out if you have any questions, thanks!

Rob Smith | Community Partner and Tribal Liaison
Oregon **H**ealth **I**nsurance **M**arketplace
Department of **C**onsumer & **B**usiness **S**ervices
(971) 301-1960
robert.d.smith@oregon.gov
oregonhealthcare.gov

You can find the page on facebook at https://www.facebook.com/ORMarketplace

Diversity and Inclusion

Proud member of DCBS's Diversity and Inclusion Council

From: CRONEN Elizabeth M * DCBS
Sent: Tuesday, July 25, 2017 3:45 PM
To: SMITH Robert D * DCBS
Cc: FLOWERS Chiqui L * DCBS; BEHRENS Anthony A * DCBS
Subject: final letter to Tribal partners ready to go

Hi, Rob,

The 1332 application is ready and posted online here: http://healthcare.oregon.gov/Documents/draft-OR1332-waiver-app.pdf. This letter to Tribes about their special consultation opportunity also is ready to go out. Can you send to your Tribal contacts, along with a copy of the application?

Elizabeth Cronen
Communications and Legislative Manager
Oregon Health Insurance Marketplace
503-569-8171
elizabeth.m.cronen@oregon.gov

Like us on facebook at: https://www.facebook.com/ORMarketplace

Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Oregon Health Insurance Marketplace
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
855-268-3767
Fax: 503-373-9422
oregonhealthcare.gov

Dear Tribal partner,

The Oregon Department of Consumer and Business Services is applying for a State Innovation Waiver from the federal government, and you are invited to consult with the department regarding the application.

Date: August 25, 2017
Time: 1 p.m. to 3 p.m.
Place: Lincoln Building, in the Pine Room; 421 SW Oak Street; Portland OR 97204
You may also consult via telephone: 712-770-4010, access code 180247

Oregon intends to use waiver authority to partially fund the Oregon Reinsurance Program. The reinsurance program, created by Oregon House Bill 2391, will reimburse carriers for high claims and will spread the cost of high-risk individuals more broadly among carriers. Oregon expects these steps will cultivate greater certainty in the market, slow the rise of health insurance premiums, and facilitate insurance companies' continued participation throughout the state in the individual and small-group markets.

About 1332 waivers
The State Innovation Waiver, also known as a 1332 waiver, is an opportunity for states to diverge from certain Affordable Care Act provisions while creating programs that help increase access to quality, affordable health insurance for their residents. Federal savings from these programs can be used to fund innovation at the state level.

Oregon's 1332 waiver application
The application specifically requests a waiver of Section 1312(c)(1) (the single risk pool requirement) under Section 1332 of the Affordable Care Act (ACA) for a period of five years to implement a state reinsurance program. The waiver will not affect any other provision of the Affordable Care Act, but is expected to lower individual health insurance premiums for Oregonians, and in turn reduce the federal government's overall premium tax credit costs.

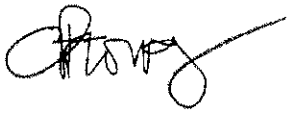
The Oregon Reinsurance Program
The Oregon Reinsurance Program (ORP) will be funded through a small portion of a 1.5-percent premium tax levied on major medical premiums for policies issued in this state and through excess fund balances currently held in two state programs. House Bill 2391 makes this funding contingent on grant of a waiver by the federal government.

In addition to state funds, the ORP also will use federal funding made possible by the premium-tax savings that the 1332 waiver will produce. The federal funding is estimated at more than $30 million per year through 2027. Total funding, including federal funds, for 2018 is estimated at $90 million. DCBS estimates that the program will reduce rates 6 percent in 2018 by reimbursing carriers for high-cost claims.

Consultation details
If you intend to consult with DCBS either in person or via telephone, you are strongly encouraged to also submit written statements to 1332.comments@oregon.gov. Written statements will be accepted through 5 p.m. on August 27, 2017.

If you have questions, please contact Rob Smith, Tribal liaison for the Oregon Health Insurance Marketplace, at robert.d.smith@oregon.gov.

Sincerely,



Chiqui Flowers
Acting Administrator
Oregon Health Insurance Marketplace