Senate Bill 1582

Sponsored by Senator COURTNEY

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Authorizes Oregon Medical Insurance Pool Board to make expenditures for transitional medical insurance pool program.

Modifies requirements for Oregon Reinsurance Program in response to changes in federal law.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to administration of health insurance; amending ORS 735.612 and section 2, chapter 698, Oregon Laws 2013; and declaring an emergency.

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

SECTION 1. ORS 735.612 is amended to read:

735.612. (1) There is established in the State Treasury, the Oregon Medical Insurance Pool Account, which shall consist of:

(a) Moneys appropriated to the account by the Legislative Assembly.

(b) Interest earnings from the investment of moneys in the account.

(c) Assessments and other revenues collected or received by the Oregon Medical Insurance Pool Board.

(2) All moneys in the Oregon Medical Insurance Pool Account are continuously appropriated to the Oregon Medical Insurance Pool Board to carry out the provisions of ORS 735.600 to 735.650 and sections 1, 2 and 4, chapter 698, Oregon Laws 2013**, and for programs administered by the board that facilitate health insurance coverage for individuals who were enrolled in pool coverage under ORS 735.600 to 735.650 on December 31, 2013**.

(3) The Oregon Medical Insurance Pool Board shall transfer to the Oregon Health Authority Fund established in ORS 413.101 an amount equal to the operating budget authorized by the Legislative Assembly or as that budget may be modified by the Emergency Board or the Oregon Department of Administrative Services, for operation of the Oregon Medical Insurance Pool Board.

SECTION 2. Section 2, chapter 698, Oregon Laws 2013, as amended by section 32, chapter 722, Oregon Laws 2013, is amended to read:

Sec. 2. (1) As used in this section, section 1, chapter 698, Oregon Laws 2013, and ORS 735.610:

(a) "Health benefit plan" has the meaning given that term in ORS 743.730.

(b) "Insurer" means an insurer described in ORS 735.605 (4)(a), (b) and (d).

(c) "Program" means the Oregon Reinsurance Program established in section 1, chapter 698, Oregon Laws 2013.

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

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

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(B) Is not a grandfathered health plan as defined in ORS 743.730; and

(C) Meets the criteria prescribed by the Oregon Medical Insurance Pool Board under subsection (2) of this section.

(e) "Reinsurance eligible individual" means an individual who is insured on or before April 1, 2014, under a reinsurance eligible health benefit plan and who was:

(A) On December 31, 2013, enrolled in the Oregon Medical Insurance Pool created in ORS 735.610;

(B) On June 30, 2013, enrolled in the Temporary High Risk Pool Program established in section 1, chapter 47, Oregon Laws 2010;

(C) On December 31, 2013, insured under a portability health benefit plan as defined in ORS 743.760; or

(D) On December 31, 2013, reinsured under the reinsurance program for children's coverage described in ORS 735.614 (1)(b).

(2) The board shall prescribe by rule the criteria for a health benefit plan to qualify for reinsurance payments under the program. The criteria must be consistent with requirements for:

(a) Premium rates under 42 U.S.C. 300gg;

(b) Guaranteed availability under 42 U.S.C. 300gg-1;

(c) Guaranteed renewability under 42 U.S.C. 300gg-2;

(d) Coverage of essential health benefits under 42 U.S.C. 18022; and

(e) Using a single risk pool under 42 U.S.C. 18032(c).

(3) 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's claims costs that exceed the attachment point, up to the reinsurance cap, as follows:

(a) For 2014:

(A) The attachment point is $30,000.

(B) The reinsurance cap is $300,000.

(C) Except as provided in paragraph (b) of this subsection, the coinsurance rate is:

(i) Ten percent for claims costs above $60,000 and up to and including $250,000; and

(ii) Ninety percent for claims costs from $30,000 and up to and including $60,000 and above $250,000.

(b) The board may lower the coinsurance rate if the reinsurance claims incurred exceed the total amount of the assessments collected under subsection (4) of this section.

(c) The board shall adopt by rule an attachment point, reinsurance cap and coinsurance rate for calendar years 2015 and 2016 that complement the federal reinsurance program requirements, so that the reinsurance claims do not exceed the total amount of the assessments collected under subsection (4) of this section. After the rules required under this paragraph are adopted for a calendar year, the board may not:

(A) Change the attachment point or the reinsurance cap adopted for that calendar year; or

(B) Increase the coinsurance rate adopted for that calendar year.

(4) The board shall impose an assessment on all insurers at a rate that is expected to produce**, at a minimum,** an amount of funds sufficient to pay administrative expenses and to make reinsurance payments that are due to issuers of reinsurance eligible health benefit plans in a calendar year, but not greater than the rate that would be expected to produce funds totaling the lesser of:

(a) An amount per month multiplied by the number of insureds and certificate holders in this state who are insured or reinsured; or

(b) The total assessment set forth in subsection (5) of this section.

(5) The amount per month and total assessment on all insurers are as follows:

(a) For calendar year 2014, the amount per month is $4 and the total assessment is $72 million.

(b) For calendar year 2015, the amount per month is $3.50 and the total assessment is $63 million.

(c) For calendar year 2016, the amount per month is $2.20 and the total assessment is $40 million.

(6) In determining the number of insureds and certificate holders in this state who are insured or reinsured, the board shall exclude individuals with the following types of coverage:

(a) The medical assistance program under ORS chapter 414;

(b) Medicare;

(c) Disability income insurance;

(d) Hospital-only insurance;

(e) Dental-only insurance;

(f) Vision-only insurance;

(g) Accident-only insurance;

(h) Automobile insurance;

(i) Specific disease insurance;

(j) Medical supplemental plans;

(k) TRICARE;

(L) Prescription drug only plans;

(m) Long term care insurance; and

(n) Federal Employees Health Benefits Program.

(7) If the board collects assessments that exceed the amount necessary to pay administrative expenses and to make all of the reinsurance payments that are due to issuers of reinsurance eligible health benefit plans in calendar years 2014, 2015 and 2016, the board shall refund the excess, on a pro rata basis, to insurers who are subject to the assessment imposed by subsection (4) of this section.

(8) The board may not impose an assessment under subsection (4) of this section for calendar years beginning with 2017.

(9) All moneys received or collected by the board under this section shall be paid into the Oregon Medical Insurance Pool Account established in ORS 735.612.

(10) The board, in consultation with the Department of Consumer and Business Services, may adopt rules necessary to carry out the provisions of this section including, but not limited to, rules prescribing:

(a) The eligibility requirements for participation in the program by an issuer of a reinsurance eligible health benefit plan;

(b) The form and manner of issuing notices of assessment amounts;

(c) The amount, manner and frequency of the payment and collection of assessments;

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

(e) Reporting requirements for insurers subject to the assessment and for issuers of reinsurance eligible health benefit plans.

SECTION 3. This 2014 Act being necessary for the immediate preservation of the public

peace, health and safety, an emergency is declared to exist, and this 2014 Act takes effect on its passage.
