House Bill 2010

Sponsored by Representative RAYFIELD, Senators STEINER HAYWARD, JOHNSON

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.**

Extends Oregon Reinsurance Program and authorizes Department of Consumer and Business Services to request extension of waiver for state innovation. Authorizes department to change attachment point or coinsurance rate for program under specified conditions.

Extends to 2026 and increases to two percent assessment on earnings from health plan premiums and payments by Oregon Health Authority to managed care organizations and includes health care stop loss coverage as subject to assessment.

Extends assessment on hospitals to 2025.

A BILL FOR AN ACT

Relating to funding to improve access to health care; creating new provisions; and amending ORS 243.135 and sections 10, 12, 13 and 14, chapter 736, Oregon Laws 2003, section 2, chapter 26, Oregon Laws 2016, and sections 3, 4, 5, 6, 8, 9, 12, 19 and 48, chapter 538, Oregon Laws 2017.

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

OREGON REINSURANCE PROGRAM

SECTION 1. Section 19, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 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

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.

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*] **only if necessary to pay out the full amount of funding budgeted for the Oregon Reinsurance Program when claims received are less than the amount of claims that were projected**:

(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 2. Section 2, chapter 26, Oregon Laws 2016, as amended by section 24, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 2. 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. The department shall apply for a waiver to receive funding to implement the Oregon Reinsurance Program established in section 18**,** [*of this 2017 Act*] **chapter 538, Oregon Laws 2017, and apply for subsequent renewals of the waiver to continue the program as long as revenue from the assessment under section 5, chapter 538, Oregon Laws 2017, is available**.

SECTION 3. Section 48, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 48. Sections 18 to 22**,** [*of this 2017 Act*] **chapter 538, Oregon Laws 2017,** are repealed on January 2, [*2024*] **2028**.

HEALTH INSURANCE PREMIUM AND MANAGED CARE ASSESSMENTS

SECTION 4. Section 3, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 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*] **insured**, 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*] **two** 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, sur-

charge 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*] **chapter 538, Oregon Laws 2017**.

SECTION 5. Section 4, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 4. Section 3**,** [*of this 2017 Act*] **chapter 538, Oregon Laws 2017,** 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*] **2020**, through December 31, [*2019*] **2026**.

SECTION 6. Section 5, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 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.*] **means:**

(A) A health benefit plan as defined in ORS 743B.005; and

(B) Insurance described in ORS 742.065.

(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*] **two** 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*] **chapter 538, Oregon Laws 2017**.

SECTION 7. Section 6, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 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*] **chapter 538, Oregon Laws 2017**, 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) If an insurer fails to timely file a verified form or to pay an assessment required under section 5, chapter 538, Oregon Laws 2017, the department shall impose a penalty on the insurer of the greater of:

(a) An amount determined under ORS 731.988; or

(b) Five percent of the assessment due for the calendar quarter.

[*(2)*] **(3)** 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*] **chapter 538, Oregon Laws 2017**.

SECTION 8. Section 8, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 8. [*(1)*] Section 5**,** [*of this 2017 Act*] **chapter 538, Oregon Laws 2017,** 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*] **the period beginning January 1, 2020, and ending December 31, 2026**.

[*(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. Section 9, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 9. (1) As used in this section and sections 10 and 11**,** [*of this 2017 Act*] **chapter 538, Oregon Laws 2017**:

(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*] **two** 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*] **chapter 538, Oregon Laws 2017**.

(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. Section 12, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 12. Sections 9, 10 and 11**,** [*of this 2017 Act*] **chapter 538, Oregon Laws 2017,** apply to any payments made to a managed care organization by the Oregon Health Authority for the period beginning January 1, [*2018*] **2020**, and ending December 31, [*2019*] **2026**.

SECTION 11. ORS 243.135, as amended by section 27, chapter 746, Oregon Laws 2017, is amended to read:

243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed

to meet the needs and provide for the welfare of eligible employees, the state and the local governments. In considering whether to enter into a contract for a plan, the board shall place emphasis on:

(a) Employee choice among high quality plans;

(b) A competitive marketplace;

(c) Plan performance and information;

(d) Employer flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

(g) Plan benefits as part of total employee compensation;

(h) The improvement of employee health; and

(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan.

(2) The board may approve more than one carrier for each type of plan contracted for and offered but the number of carriers shall be held to a number consistent with adequate service to eligible employees and their family members.

(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members who are not enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board. An eligible employee who declines coverage in a health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse or family member in another health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board may not be paid the employer contribution for the plan that was declined.

(4) Payroll deductions for costs that are not payable by the state or a local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

(5) In developing any health benefit plan, the board may provide an option of additional coverage for eligible employees and their family members at an additional cost or premium.

(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and their family members under rules adopted by the board. Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

(7) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

(8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by the board that are designed to limit the growth in per-member expenditures for health services to no more than 3.4 percent per year. **The assessment paid in accordance with section 3, chapter 538, Oregon Laws 2017, shall be excluded in determining the 3.4 percent annual increase in per-member expenditures for health services.**

(b) The board shall adopt policies and practices designed to limit the annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.

(9) A carrier or third party administrator that contracts with the board to provide or administer a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.

(10) By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care.

(11) No later than February 1 of each year, the board shall report to the Legislative Assembly on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care.

SECTION 12. ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, and section 27, chapter 746, Oregon Laws 2017, is amended to read:

243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees, the state and the local governments. In considering whether to enter into a contract for a plan, the board shall place emphasis on:

(a) Employee choice among high quality plans;

(b) A competitive marketplace;

(c) Plan performance and information;

(d) Employer flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

(g) Plan benefits as part of total employee compensation;

(h) The improvement of employee health; and

(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan.

(2) The board may approve more than one carrier for each type of plan contracted for and offered but the number of carriers shall be held to a number consistent with adequate service to eligible employees and their family members.

(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members who are not enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board. An eligible employee who declines coverage in a health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse or family member in another health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board may not be paid the employer contribution for the plan that was declined.

(4) Payroll deductions for costs that are not payable by the state or a local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

(5) In developing any health benefit plan, the board may provide an option of additional coverage for eligible employees and their family members at an additional cost or premium.

(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and their family members under rules adopted by the board. Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable

provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

(7) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

(8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by the board that are designed to limit the growth in per-member expenditures for health services to no more than 3.4 percent per year. **The assessment paid in accordance with section 3, chapter 538, Oregon Laws 2017, shall be excluded in determining the 3.4 percent annual increase in per-member expenditures for health services.**

(b) The board shall adopt policies and practices designed to limit the annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.

(9) A carrier or third party administrator that contracts with the board to provide or administer a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.

(10) If the board spends less than 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care, the board shall implement a plan for increasing the percentage of total medical expenditures spent on payments for primary care by at least one percent each year.

(11) No later than February 1 of each year, the board shall report to the Legislative Assembly on any plan implemented under subsection (10) of this section and on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care.

EXTENSION OF HOSPITAL ASSESSMENT

SECTION 13. 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, section 2, chapter 16, Oregon Laws 2015, and section 37a, chapter 538, Oregon Laws 2017, 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*] **July 1, 2019**, and ending the earlier of September 30, [*2021*] **2025**, 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 14. 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, section 3, chapter 16, Oregon Laws 2015, and section 38, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 12. (1) Sections 1 to 9, chapter 736, Oregon Laws 2003, are repealed on January 2, [*2026*] **2031**.

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

SECTION 15. 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, section 4, chapter 16, Oregon Laws 2015, and section 39, chapter 538, Oregon Laws 2017, 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, [*2021*] **2025**.

SECTION 16. Section 14, chapter 736, Oregon Laws 2003, as amended by section 6, chapter 780, Oregon Laws 2007, section 23, chapter 867, Oregon Laws 2009, section 5, chapter 16, Oregon Laws 2015, and section 40, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 14. Any moneys remaining in the Hospital Quality Assurance Fund on December 31, [*2025*] **2031**, are transferred to the General Fund.

CAPTIONS

SECTION 17. The unit captions used in this 2019 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 2019 Act.