House Bill 3033

Sponsored by Representative DEMBROW

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.**

Reduces Oregon Medical Insurance Pool assessment for reinsurers.

A BILL FOR AN ACT

Relating to Oregon Medical Insurance Pool assessment; amending ORS 735.614.

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

SECTION 1. ORS 735.614 is amended to read:

735.614. (1) If the Oregon Medical Insurance Pool Board determines at any time that funds in the Oregon Medical Insurance Pool Account are or will become insufficient for payment of expenses of the pool in a timely manner, the board shall determine the amount of funds needed and shall impose and collect assessments against insurers, as provided in this section, in the amount of the funds determined to be needed.

(2) Each insurer's assessment shall be determined by multiplying the total amount [*to be assessed*] **of funds needed under subsection (1) of this section** by a fraction[*,*]**.** The numerator of [*which*] **the fraction** equals the **sum of that insurer's total** number of Oregon [*insureds and certificate holders insured or reinsured by each insurer, and*] **covered lives, excluding those that are reinsured, plus 10 percent of the number of that insurer's Oregon covered lives that are reinsured.** The denominator of [*which*] **the fraction** equals the **sum of the** total **number of Oregon covered lives insured by all insurers in this state, excluding the covered lives that are reinsured, plus 10 percent of the total number of Oregon covered lives that are reinsured by all insurers in this state. The number of covered lives shall be determined as of March 31 of each year.** [*of all Oregon insureds and certificate holders insured or reinsured by all insurers, all determined as of March 31 each year.*]

(3) The board shall ensure that each [*insured and certificate holder*] **covered life** is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains reinsurance for its [*insureds and certificate holders*] **covered lives** to include in its count [*of insureds and certificate holders all insureds and certificate holders whose coverage is*] **all of the covered lives that are** reinsured in whole or part. The board shall allow an insurer [*who*] **that** is a reinsurer to exclude from its [*number of insureds those*] **count all of the covered lives** that have been counted by the primary insurer or the primary reinsurer for the purpose of determining [*its*] **the amount of the primary insurer's or primary reinsurer's** assessment under this subsection.

(4) All insurers authorized to transact medical insurance in Oregon and that insure persons residing in Oregon are subject to the assessment under this section. Insureds under the following types of coverage, as defined by rule by the board, are [*excluded*] **not counted as covered lives** in the calculation of the assessment:

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.

(a) Medicaid;

(b) State Children's Health Insurance Program;

(c) Medicare;

(d) Disability income insurance;

(e) Hospital only insurance;

(f) Dental insurance;

(g) Vision only insurance;

(h) Accident only insurance;

(i) Automobile insurance;

(j) Specific disease insurance;

(k) Medical supplemental plans;

(L) TRICARE;

(m) CHAMPUS;

(n) Prescription drug only plans;

(o) Long term care insurance; and

(p) Federal Employees Health Benefits Program.

(5) If assessments exceed the amounts actually needed, the excess shall be held and invested and, with the earnings and interest, used by the board to offset future net losses or to reduce pool premiums. For purposes of this subsection, "future net losses" includes reserves for claims incurred but not reported.

(6) Each insurer's proportion of participation in the pool shall be determined by the board based on annual statements and other reports deemed necessary by the board and filed by the insurer with the board. The board may use any reasonable method of estimating the number of [*insureds and certificate holders*] **covered lives** of an insurer if the specific number is unknown. With respect to insurers that are reinsurers, the board may use any reasonable method of estimating the number of [*persons insured by*] **covered lives for** each reinsurer.

(7) The board may abate or defer, in whole or in part, the assessment of an insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the insurer to fulfill the insurer's contractual obligations. In the event an assessment against an insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this section. The insurer receiving the abatement or deferment shall remain liable to the board for the deficiency for four years.

(8) The board shall abate or defer assessments authorized by this section if a court orders that assessments cannot be made applicable to reinsurers. However, if a court orders that assessments cannot be made applicable to reinsurers, the board may continue to assess insurers to the end of the biennium in which the determination is made **using the number of covered lives that are not reinsured on a statewide basis and for each insurer subject to the assessment**.

(9) Subject to the approval of the Director of the Oregon Health Authority, the board may develop a program for adjusting the assessment of an insurer in the individual health benefits market based on that insurer's contribution to reducing the enrollment in the Oregon Medical Insurance Pool. When developing the program, the board may consider, but is not limited to, the following factors:

(a) The insurer's level of participation;

(b) Level of health benefit plan coverage offered; and

(c) Assumption of risk in the individual health benefits market.