Senate Bill 103

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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.**

Expands types of entities subject to Oregon Medical Insurance Pool assessment to include third party administrators for self-insurance arrangements.

A BILL FOR AN ACT

Relating to Oregon Medical Insurance Pool assessment; amending ORS 414.872, 735.605 and 735.614.

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

SECTION 1. ORS 735.605 is amended to read:

735.605. As used in ORS 735.600 to 735.650:

(1) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to ORS 735.600 to 735.650.

(2) "Board" means the Oregon Medical Insurance Pool Board.

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

[*(3)*] **(4)** "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer.

[*(4)*] **(5)** "Insurer" means:

(a) Any insurer [*as defined in ORS 731.106*] or fraternal benefit society [*as defined in ORS 748.106*] required to have a certificate of authority to transact health insurance business in this state, and any health care service contractor as defined in ORS 750.005.

(b) Any reinsurer reinsuring medical insurance in this state.

(c) To the extent consistent with federal law, any self-insurance arrangement covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state.

(d) All self-insurance arrangements not covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state.

(e) A third party administrator for a self-insurance arrangement.

[*(5)*] **(6)** "Medical insurance" means insurance of humans against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness or childbirth, or against expense incurred in prevention of sickness, in dental care or optometrical service, and every insurance appertaining thereto, including insurance against the risk of economic loss assumed under a less than fully insured employee health benefit plan. "Medical insurance" does not include workers' compensation coverages.

[*(6)*] **(7)** "Medicare" means coverage under Part A, Part B and Part D of Title XVIII of the Social Security Act, 42 U.S.C. 1395c et seq., as amended.

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.

[*(7)*] **(8)** "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to ORS 735.600 to 735.650.

[*(8)*] **(9)** "Pool" means the Oregon Medical Insurance Pool as created by ORS 735.610.

[*(9)*] **(10)** "Reinsurer" means any insurer [*as defined in ORS 731.106*] from whom any person providing medical insurance to Oregon insureds procures insurance for itself in the insurer, with respect to all or part of the medical insurance risk of the person. **"Reinsurer" includes an insurer providing insurance against the risk of economic loss.**

[*(10)*] **(11)** "Self-insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide health care services or benefits to their employees or members in this state, either directly or indirectly through a trust or third party administrator, unless the health care services or benefits are provided by an insurance policy issued by an insurer other than a self-insurance arrangement.

(12) "Third party administrator" means any person required to obtain a license pursuant to ORS 744.702.

SECTION 2. 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 **timely** 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*] **upon and collect from insurers assessments determined in accordance with subsection (2) of this section**.

(2) Each insurer's assessment shall be determined by multiplying the total amount to be assessed by a fraction, the numerator of which equals the number of **the insurer's covered lives in this state** [*Oregon insureds and certificate holders insured or reinsured by each insurer*], and the denominator of which equals the total **number** of [*all Oregon insureds and certificate holders insured or reinsured by all insurers*] **covered lives in this state**, all determined as of March 31 each year.

(3) The board shall [*ensure that each insured and certificate holder is counted*] **count each covered life** 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 to include in its count of insureds and certificate holders all insureds and certificate holders whose coverage is reinsured in whole or part. The board shall allow an insurer who is a reinsurer to exclude from its number of insureds those that have been counted by the primary insurer or the primary reinsurer for the purpose of determining its assessment under this subsection.*] **the total number of covered lives in this state includes the number of covered lives:**

(a) In an insurer's fully insured and less than fully insured health benefit plans;

(b) Not counted under paragraph (a) of this subsection, in an insurer's less than fully insured health benefit plans that are administered by a third party administrator; and

(c) Not counted in paragraph (a) or (b) of this subsection, in all less than fully insured health benefit plans that are covered by reinsurance issued by an insurer.

(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 in the calculation of the assessment*] **In the determination of the assessment under subsections (2) and (3) of this section, covered lives do not include individuals covered by any of the following**:

(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*] **the total number of covered lives in this state under subsection (2) of this section** 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 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.

(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.

SECTION 3. ORS 414.872 is amended to read:

414.872. (1) Of payments made to the Family Health Insurance Assistance Program by the Oregon Health Authority under ORS 414.870 (4), the authority shall determine:

(a) The portion of a subsidy of a subsidized member that is from the General Fund; and

(b) The portion of other costs that is from the General Fund.

(2) The authority shall bill the program for the amounts determined under subsection (1) of this section. The program shall forward the bill for the amount determined under subsection (1)(b) of this section to the Oregon Medical Insurance Pool Board.

(3) The board shall:

(a) Determine the amount of funds needed for the payment of other costs under subsection (1)(b) of this section; and

(b) Impose and collect assessments in that amount against insurers, using the methodology described in ORS 735.614 [*(2), (6) and (9)*].

(4) The board shall pay the program for the amounts determined under subsection (1)(b) of this section.

(5) The program shall forward to the authority the amounts determined under subsection (1) of this section.

(6) ORS 735.614 [*(3), (4), (5), (7) and (8)*] applies to assessments collected under this section.