HOUSE AMENDMENTS TO HOUSE BILL 3458

By COMMITTEE ON HEALTH CARE

April 3

On page 1 of the printed bill, delete lines 10 through 30 and delete page 2.

On page 3, delete lines 1 through 26 and insert:

"ESTABLISHMENT OF THE
OREGON REINSURANCE PROGRAM

"SECTION 1. The Oregon Reinsurance Program is established in the Oregon Health Authority. The program shall be administered by the Oregon Medical Insurance Pool Board, created in ORS 735.610, 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 by providing state reinsurance payments to insurers from assessments described in section 2 of this 2013 Act.

"SECTION 2. (1) As used in this section, section 1 of this 2013 Act 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 of this 2013 Act.

"(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;

"(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, on December 31, 2013, was:

"(A) Enrolled in the Oregon Medical Insurance Pool created in ORS 735.610 or the Temporary High Risk Pool Program established in section 1, chapter 47, Oregon Laws 2010;

"(B) Insured under a portability health benefit plan as defined in ORS 743.760; or

"(C) 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 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.".

In line 27, delete "Section 4 of this 2013 Act is" and insert "Sections 4 and 4a of this 2013 Act are".

In line 31, delete "Supplemental".

In line 38, delete "Supplemental".

After line 39, insert:

"**SECTION 4a. In a rate filing under ORS 743.018, an insurer must identify the impact of:**

"(1) State reinsurance payments under section 2 of this 2013 Act and federal reinsurance payments on projected claims costs and in the development of rates; and

"(2) Assessments imposed under section 2 of this 2013 Act on rates.".

On page 6, line 29, delete "Supplemental".

On page 7, delete lines 7 through 45.

On page 8, delete lines 1 through 13 and insert:

"**SECTION 6.** ORS 735.610 is amended to read:

"735.610. (1) There is created in the Oregon Health Authority the Oregon Medical Insurance Pool Board. The board shall establish the Oregon Medical Insurance Pool and otherwise carry out the responsibilities of the board under ORS 735.600 to 735.650 **and sections 1, 2 and 4 of this 2013 Act**.

"(2)**(a)** The board shall consist of [*10*] **12** individuals, [*eight*] **10** of whom shall be appointed by the Director of the Oregon Health Authority. The Director of the Department of Consumer and Business Services or the director's designee and the Director of the Oregon Health Authority or the director's designee shall be members of the board. The chair of the board shall be elected from among the members of the board. The board shall at all times, to the extent possible, include at least**:**

"(A) One representative of a domestic insurance company licensed to transact health insurance[*,*]**;**

"(B) One representative of a domestic not-for-profit health care service contractor[*,*]**;**

"(C) One representative of a health maintenance organization[*,*]**;**

"(D) One representative of reinsurers**;** and

"(E) [*two*] **Four** members of the general public**:**

"(i) Who are not associated with the medical profession, a hospital or an insurer[*.*]**; and**

"(ii) Two of whom represent businesses that purchase health insurance coverage that is subject to the assessments under section 2 of this 2013 Act.

"(b) A majority of the voting members of the board constitutes a quorum for the transaction of business. An act by a majority of a quorum is an official act of the board.

"(3) The Director of the Oregon Health Authority may fill any vacancy on the board by appointment.

"(4) The board shall have the [*general powers and authority under the laws of this state granted to insurance companies with a certificate of authority to transact health insurance and the*] specific authority to:

"(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of ORS 735.600 to 735.650 including the authority to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

"(b) Recover any assessments for, on behalf of, or against insurers;

"(c) Take such legal action as is necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

"[*(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, insurance producers' referral fees, claim reserves or formulas and perform any other actuarial function appropriate to the operation of the pool. Rates may not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;*]

"[*(e) Issue policies of insurance in accordance with the requirements of ORS 735.600 to 735.650;*]

"[*(f)*] **(d)** Appoint from among insurers appropriate actuarial and other committees as necessary to provide technical assistance in the operation of the pool[*, policy and other contract design*] **and the Oregon Reinsurance Program**, and **for** any other function within the authority of the board;

"[*(g)*] **(e)** Seek advances to effect the purposes of the pool **and the program**; and

"[*(h)*] **(f)** Establish rules, conditions and procedures for reinsuring risks under ORS 735.600 to

735.650 **and the operation of and participation of issuers of reinsurance eligible health benefit plans in the program**.

"(5) Each member of the board is entitled to compensation and expenses as provided in ORS 292.495.

"(6) The Director of the Oregon Health Authority shall adopt rules, as provided under ORS chapter 183, implementing policies recommended by the board for the purpose of carrying out ORS 735.600 to 735.650 **and sections 1, 2 and 4 of this 2013 Act**.

"(7) In consultation with the board, the Director of the Oregon Health Authority shall employ such staff and consultants as may be necessary for the purpose of carrying out responsibilities under ORS 735.600 to 735.650 **and sections 1, 2 and 4 of this 2013 Act**.".

In line 15, delete "Supple-".

In line 16, delete "mental".

In line 24, delete "Supplemental".

Delete lines 30 through 45 and delete page 9.

On page 10, delete lines 1 through 3 and insert:

"**SECTION 9.** 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 the State Board of Higher Education and the public universities 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 [*and premiums paid to*] **imposed by** the Oregon Medical Insurance Pool [*established by ORS 735.614 and 735.625*] **Board under section 2 of this 2013 Act**.

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

"(D) Assessments paid to the Department of Consumer and Business Services under ORS 743.951

and 743.961.

"(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) Any charges established by the State Parks and Recreation Director in accordance with ORS 565.080 (3).

"(j) 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.

"(k) 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.

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

"(m) 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.

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

"(o) Convenience fees as defined in ORS 182.126 and established by the Oregon Department of Administrative Services 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.".

On page 12, delete lines 13 through 45 and delete pages 13 and 14.

On page 15, delete line 1 and insert:

"**SECTION 12.** ORS 731.036 is amended to read:

"731.036. Except as provided in ORS 743.061 or as specifically provided by law, the Insurance Code does not apply to any of the following to the extent of the subject matter of the exemption:

"(1) A bail bondsman, other than a corporate surety and its agents.

"(2) A fraternal benefit society that has maintained lodges in this state and other states for 50 years prior to January 1, 1961, and for which a certificate of authority was not required on that date.

"(3) A religious organization providing insurance benefits only to its employees, if the organ-

ization is in existence and exempt from taxation under section 501(c)(3) of the federal Internal Revenue Code on September 13, 1975.

"(4) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for tort liability in accordance with ORS 30.282.

"(5) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for property damage in accordance with ORS 30.282.

"(6) Cities, counties, school districts, community college districts, community college service districts or districts, as defined in ORS 198.010 and 198.180, that either individually or jointly insure for health insurance coverage, excluding disability insurance, their employees or retired employees, or their dependents, or students engaged in school activities, or combination of employees and dependents, with or without employee or student contributions, if all of the following conditions are met:

"(a) The individual or jointly self-insured program meets the following minimum requirements:

"(A) In the case of a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals;

"(B) In the case of an individual public body program other than a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals; and

"(C) In the case of a joint program of two or more public bodies, the number of covered employees and dependents and retired employees and dependents aggregates at least 1,000 individuals;

"(b) The individual or jointly self-insured health insurance program includes all coverages and benefits required of group health insurance policies under ORS chapters 743 and 743A;

"(c) The individual or jointly self-insured program must have program documents that define program benefits and administration;

"(d) Enrollees must be provided copies of summary plan descriptions including:

"(A) Written general information about services provided, access to services, charges and scheduling applicable to each enrollee's coverage;

"(B) The program's grievance and appeal process; and

"(C) Other group health plan enrollee rights, disclosure or written procedure requirements established under ORS chapters 743 and 743A;

"(e) The financial administration of an individual or jointly self-insured program must include the following requirements:

"(A) Program contributions and reserves must be held in separate accounts and used for the exclusive benefit of the program;

"(B) The program must maintain adequate reserves. Reserves may be invested in accordance with the provisions of ORS chapter 293. Reserve adequacy must be calculated annually with proper actuarial calculations including the following:

"(i) Known claims, paid and outstanding;

"(ii) A history of incurred but not reported claims;

"(iii) Claims handling expenses;

"(iv) Unearned contributions; and

"(v) A claims trend factor; and

"(C) The program must maintain adequate reinsurance against the risk of economic loss in accordance with the provisions of ORS 742.065 unless the program has received written approval for

an alternative arrangement for protection against economic loss from the Director of the Department of Consumer and Business Services;

"(f) The individual or jointly self-insured program must have sufficient personnel to service the employee benefit program or must contract with a third party administrator licensed under ORS chapter 744 as a third party administrator to provide such services;

"(g) The individual or jointly self-insured program shall be subject to assessment in accordance with [*ORS 735.614 and former enrollees shall be eligible for portability coverage in accordance with ORS 735.616*] **section 2 of this 2013 Act**;

"(h) The public body, or the program administrator in the case of a joint insurance program of two or more public bodies, files with the Director of the Department of Consumer and Business Services copies of all documents creating and governing the program, all forms used to communicate the coverage to beneficiaries, the schedule of payments established to support the program and, annually, a financial report showing the total incurred cost of the program for the preceding year. A copy of the annual audit required by ORS 297.425 may be used to satisfy the financial report filing requirement; and

"(i) Each public body in a joint insurance program is liable only to its own employees and no others for benefits under the program in the event, and to the extent, that no further funds, including funds from insurance policies obtained by the pool, are available in the joint insurance pool.

"(7) All ambulance services.

"(8) A person providing any of the services described in this subsection. The exemption under this subsection does not apply to an authorized insurer providing such services under an insurance policy. This subsection applies to the following services:

"(a) Towing service.

"(b) Emergency road service, which means adjustment, repair or replacement of the equipment, tires or mechanical parts of a motor vehicle in order to permit the motor vehicle to be operated under its own power.

"(c) Transportation and arrangements for the transportation of human remains, including all necessary and appropriate preparations for and actual transportation provided to return a decedent's remains from the decedent's place of death to a location designated by a person with valid legal authority under ORS 97.130.

"(9)(a) A person described in this subsection who, in an agreement to lease or to finance the purchase of a motor vehicle, agrees to waive for no additional charge the amount specified in paragraph (b) of this subsection upon total loss of the motor vehicle because of physical damage, theft or other occurrence, as specified in the agreement. The exemption established in this subsection applies to the following persons:

"(A) The seller of the motor vehicle, if the sale is made pursuant to a motor vehicle retail installment contract.

"(B) The lessor of the motor vehicle.

"(C) The lender who finances the purchase of the motor vehicle.

"(D) The assignee of a person described in this paragraph.

"(b) The amount waived pursuant to the agreement shall be the difference, or portion thereof, between the amount received by the seller, lessor, lender or assignee, as applicable, that represents the actual cash value of the motor vehicle at the date of loss, and the amount owed under the agreement.

"(10) A self-insurance program for tort liability or property damage that is established by two

or more affordable housing entities and that complies with the same requirements that public bodies must meet under ORS 30.282 (6). As used in this subsection:

"(a) 'Affordable housing' means housing projects in which some of the dwelling units may be purchased or rented, with or without government assistance, on a basis that is affordable to individuals of low income.

"(b) 'Affordable housing entity' means any of the following:

"(A) A housing authority created under the laws of this state or another jurisdiction and any agency or instrumentality of a housing authority, including but not limited to a legal entity created to conduct a self-insurance program for housing authorities that complies with ORS 30.282 (6).

"(B) A nonprofit corporation that is engaged in providing affordable housing.

"(C) A partnership or limited liability company that is engaged in providing affordable housing and that is affiliated with a housing authority described in subparagraph (A) of this paragraph or a nonprofit corporation described in subparagraph (B) of this paragraph if the housing authority or nonprofit corporation:

"(i) Has, or has the right to acquire, a financial or ownership interest in the partnership or limited liability company;

"(ii) Has the power to direct the management or policies of the partnership or limited liability company;

"(iii) Has entered into a contract to lease, manage or operate the affordable housing owned by the partnership or limited liability company; or

"(iv) Has any other material relationship with the partnership or limited liability company.

"(11) A community-based health care initiative approved by the Administrator of the Office for Oregon Health Policy and Research under ORS 735.723 operating a community-based health care improvement program approved by the administrator.

"(12) Except as provided in ORS 735.500 and 735.510, a person certified by the Department of Consumer and Business Services to operate a retainer medical practice.".

On page 17, line 37, before the period insert "and sections 1, 2 and 4 of this 2013 Act".

On page 19, line 11, delete "until" and insert ". The board may not offer coverage under this section after".

On page 25, delete lines 20 through 45.

On page 26, delete lines 1 through 8 and insert:

"**SECTION 21.** ORS 743.748, as amended by section 18, chapter 500, Oregon Laws 2011, is amended to read:

"743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

"(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

"(A) The total number of members;

"(B) The total amount of premiums;

"(C) The total amount of costs for claims;

"(D) The medical loss ratio;

"(E) The average amount of premiums per member per month; and

"(F) The percentage change in the average premium per member per month, measured from the previous year.

"(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

"(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses and the assessment against the carrier for the Oregon [*Medical Insurance Pool*] **Reinsurance Program**;

"(B) The total amount of the surplus maintained;

"(C) The total amount of the reserves maintained for unpaid claims;

"(D) The total net underwriting gain or loss; and

"(E) The carrier's net income after taxes.

"(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule.

"(3) The department shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

"(a) Individual health benefit plans;

"(b) Health benefit plans for small employers;

"(c) Health benefit plans for employers described in ORS 743.733; and

"(d) Health benefit plans for employers with more than 50 employees.

"(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet.".

On page 35, line 42, delete ", 35 and 36" and insert "and 35 to 39".

In line 43, delete "39" and insert "42".

On page 42, line 32, after "date" insert "of section 26 of this 2013 Act, as" and delete "38" and insert "41".

Delete lines 34 through 45 and delete pages 43 through 45.

On page 46, delete lines 1 through 4 and insert:

"**SUNSET OF OREGON REINSURANCE PROGRAM**

"**SECTION 35.** ORS 731.509, as amended by section 5 of this 2013 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 1 of this 2013 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.

"**SECTION 36.** ORS 291.055, as amended by section 9 of this 2013 Act, is amended to read:

"291.055. (1) Notwithstanding any other law that grants to a state agency the authority to es-

tablish 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 the State Board of Higher Education and the public universities 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 of this 2013 Act.*]

"[*(C)*] **(B)** Copayments and premiums paid to the Oregon medical assistance program.

"[*(D)*] **(C)** Assessments paid to the Department of Consumer and Business Services under ORS 743.951 and 743.961.

"(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) Any charges established by the State Parks and Recreation Director in accordance with ORS 565.080 (3).

"(j) 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.

"(k) 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.

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

"(m) 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.

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

"(o) Convenience fees as defined in ORS 182.126 and established by the Oregon Department of Administrative Services 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 37.** ORS 731.036, as amended by section 12 of this 2013 Act, is amended to read:

"731.036. Except as provided in ORS 743.061 or as specifically provided by law, the Insurance Code does not apply to any of the following to the extent of the subject matter of the exemption:

"(1) A bail bondsman, other than a corporate surety and its agents.

"(2) A fraternal benefit society that has maintained lodges in this state and other states for 50 years prior to January 1, 1961, and for which a certificate of authority was not required on that date.

"(3) A religious organization providing insurance benefits only to its employees, if the organization is in existence and exempt from taxation under section 501(c)(3) of the federal Internal Revenue Code on September 13, 1975.

"(4) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for tort liability in accordance with ORS 30.282.

"(5) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for property damage in accordance with ORS 30.282.

"(6) Cities, counties, school districts, community college districts, community college service districts or districts, as defined in ORS 198.010 and 198.180, that either individually or jointly insure for health insurance coverage, excluding disability insurance, their employees or retired employees, or their dependents, or students engaged in school activities, or combination of employees and dependents, with or without employee or student contributions, if all of the following conditions are met:

"(a) The individual or jointly self-insured program meets the following minimum requirements:

"(A) In the case of a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals;

"(B) In the case of an individual public body program other than a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals; and

"(C) In the case of a joint program of two or more public bodies, the number of covered employees and dependents and retired employees and dependents aggregates at least 1,000 individuals;

"(b) The individual or jointly self-insured health insurance program includes all coverages and benefits required of group health insurance policies under ORS chapters 743 and 743A;

"(c) The individual or jointly self-insured program must have program documents that define program benefits and administration;

"(d) Enrollees must be provided copies of summary plan descriptions including:

"(A) Written general information about services provided, access to services, charges and scheduling applicable to each enrollee's coverage;

"(B) The program's grievance and appeal process; and

"(C) Other group health plan enrollee rights, disclosure or written procedure requirements established under ORS chapters 743 and 743A;

"(e) The financial administration of an individual or jointly self-insured program must include the following requirements:

"(A) Program contributions and reserves must be held in separate accounts and used for the exclusive benefit of the program;

"(B) The program must maintain adequate reserves. Reserves may be invested in accordance with the provisions of ORS chapter 293. Reserve adequacy must be calculated annually with proper actuarial calculations including the following:

"(i) Known claims, paid and outstanding;

"(ii) A history of incurred but not reported claims;

"(iii) Claims handling expenses;

"(iv) Unearned contributions; and

"(v) A claims trend factor; and

"(C) The program must maintain adequate reinsurance against the risk of economic loss in accordance with the provisions of ORS 742.065 unless the program has received written approval for an alternative arrangement for protection against economic loss from the Director of the Department of Consumer and Business Services;

"(f) The individual or jointly self-insured program must have sufficient personnel to service the employee benefit program or must contract with a third party administrator licensed under ORS chapter 744 as a third party administrator to provide such services;

"[*(g) The individual or jointly self-insured program shall be subject to assessment in accordance with section 2 of this 2013 Act;*]

"[*(h)*] **(g)** The public body, or the program administrator in the case of a joint insurance program of two or more public bodies, files with the Director of the Department of Consumer and Business Services copies of all documents creating and governing the program, all forms used to communicate the coverage to beneficiaries, the schedule of payments established to support the program and, annually, a financial report showing the total incurred cost of the program for the preceding year. A copy of the annual audit required by ORS 297.425 may be used to satisfy the financial report filing requirement; and

"[*(i)*] **(h)** Each public body in a joint insurance program is liable only to its own employees and no others for benefits under the program in the event, and to the extent, that no further funds, including funds from insurance policies obtained by the pool, are available in the joint insurance pool.

"(7) All ambulance services.

"(8) A person providing any of the services described in this subsection. The exemption under

this subsection does not apply to an authorized insurer providing such services under an insurance policy. This subsection applies to the following services:

"(a) Towing service.

"(b) Emergency road service, which means adjustment, repair or replacement of the equipment, tires or mechanical parts of a motor vehicle in order to permit the motor vehicle to be operated under its own power.

"(c) Transportation and arrangements for the transportation of human remains, including all necessary and appropriate preparations for and actual transportation provided to return a decedent's remains from the decedent's place of death to a location designated by a person with valid legal authority under ORS 97.130.

"(9)(a) A person described in this subsection who, in an agreement to lease or to finance the purchase of a motor vehicle, agrees to waive for no additional charge the amount specified in paragraph (b) of this subsection upon total loss of the motor vehicle because of physical damage, theft or other occurrence, as specified in the agreement. The exemption established in this subsection applies to the following persons:

"(A) The seller of the motor vehicle, if the sale is made pursuant to a motor vehicle retail installment contract.

"(B) The lessor of the motor vehicle.

"(C) The lender who finances the purchase of the motor vehicle.

"(D) The assignee of a person described in this paragraph.

"(b) The amount waived pursuant to the agreement shall be the difference, or portion thereof, between the amount received by the seller, lessor, lender or assignee, as applicable, that represents the actual cash value of the motor vehicle at the date of loss, and the amount owed under the agreement.

"(10) A self-insurance program for tort liability or property damage that is established by two or more affordable housing entities and that complies with the same requirements that public bodies must meet under ORS 30.282 (6). As used in this subsection:

"(a) 'Affordable housing' means housing projects in which some of the dwelling units may be purchased or rented, with or without government assistance, on a basis that is affordable to individuals of low income.

"(b) 'Affordable housing entity' means any of the following:

"(A) A housing authority created under the laws of this state or another jurisdiction and any agency or instrumentality of a housing authority, including but not limited to a legal entity created to conduct a self-insurance program for housing authorities that complies with ORS 30.282 (6).

"(B) A nonprofit corporation that is engaged in providing affordable housing.

"(C) A partnership or limited liability company that is engaged in providing affordable housing and that is affiliated with a housing authority described in subparagraph (A) of this paragraph or a nonprofit corporation described in subparagraph (B) of this paragraph if the housing authority or nonprofit corporation:

"(i) Has, or has the right to acquire, a financial or ownership interest in the partnership or limited liability company;

"(ii) Has the power to direct the management or policies of the partnership or limited liability company;

"(iii) Has entered into a contract to lease, manage or operate the affordable housing owned by the partnership or limited liability company; or

"(iv) Has any other material relationship with the partnership or limited liability company.

"(11) A community-based health care initiative approved by the Administrator of the Office for Oregon Health Policy and Research under ORS 735.723 operating a community-based health care improvement program approved by the administrator.

"(12) Except as provided in ORS 735.500 and 735.510, a person certified by the Department of Consumer and Business Services to operate a retainer medical practice.

"**SECTION 38.** ORS 743.748, as amended by section 18, chapter 500, Oregon Laws 2011, and section 21 of this 2013 Act, is amended to read:

"743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

"(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

"(A) The total number of members;

"(B) The total amount of premiums;

"(C) The total amount of costs for claims;

"(D) The medical loss ratio;

"(E) The average amount of premiums per member per month; and

"(F) The percentage change in the average premium per member per month, measured from the previous year.

"(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

"(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses [*and the assessment against the carrier for the Oregon Reinsurance Program*];

"(B) The total amount of the surplus maintained;

"(C) The total amount of the reserves maintained for unpaid claims;

"(D) The total net underwriting gain or loss; and

"(E) The carrier's net income after taxes.

"(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule.

"(3) The department shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

"(a) Individual health benefit plans;

"(b) Health benefit plans for small employers;

"(c) Health benefit plans for employers described in ORS 743.733; and

"(d) Health benefit plans for employers with more than 50 employees.

"(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet.".

In line 8, delete "36" and insert "39".

In line 34, delete "37" and insert "40".

In line 40, delete "38" and insert "41" and delete "and 4" and insert ", 4 and 4a".

In line 41, after "to" insert "20, 22 to" and delete "36" and insert "39".

In line 43, after "35" insert "to 38".

After line 43, insert:

"(3) The amendments to ORS 743.748 by section 21 of this 2013 Act become operative April 2, 2014.".

In line 44, delete "39" and insert "42".

On page 47, line 1, delete "and 4" and insert ", 4 and 4a".

In line 7, delete "40" and insert "43".
