Enrolled
House Bill 2010

Sponsored by Representative FAHEY; Representatives GAMBA, TRAN (at the request of Governor Tina Kotek) (Presession filed.)

CHAPTER .....

AN ACT

Relating to funding to improve access to health care; creating new provisions; amending ORS 243.135, 291.055, 317A.100, 414.853, 414.855, 414.871, 414.884, 415.500, 731.292, 731.509 and 731.840 and sections 12, 13 and 14, chapter 736, Oregon Laws 2003, sections 4, 8 and 48, chapter 538, Oregon Laws 2017, and section 19, chapter 2, Oregon Laws 2019; repealing ORS 414.871, 414.880, 414.882, 414.884 and 414.902 and sections 2, 3, 4, 5, 6, 7 and 8, chapter 538, Oregon Laws 2017; and prescribing an effective date.

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

HEALTH INSURANCE PREMIUM ASSESSMENT AND OREGON REINSURANCE PROGRAM

SECTION 1. Section 4, chapter 538, Oregon Laws 2017, as amended by section 5, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 4. Section 3, 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, 2020, through December 31, [*2026*] **2032**.

SECTION 2. Section 8, chapter 538, Oregon Laws 2017, as amended by section 8, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 8. Section 5, chapter 538, Oregon Laws 2017, applies to premiums earned by an insurer for the period beginning January 1, 2020, and ending December 31, [*2026*] **2032**.

SECTION 3. ORS 731.509 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 the intent of the Legislative Assembly is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom insurers and reinsurers 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 the alien insurer's or reinsurer's United States obligations in accordance with ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the assets representing the security must be maintained in the United States and claims must be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets must 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 insur-

ers. 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 may 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 (4) of this section;

(b) Subsection (5) of this section and ORS 731.511 (1);

(c) Subsection (6) of this section;

(d) Subsections (7) and (8) of this section;

(e) ORS 731.511; [*or*]

(f)(A) Subsection (9) of this section; and

(B) Additional requirements that the director specifies by rule, which may include:

(i) The valuation of assets or reserve credits;

(ii) The amount and forms of security that support reinsurance arrangements; and

(iii) The circumstances under which the director will reduce or eliminate credit[.]**; or**

(g) Subsection (10) of this section.

(3) The director shall allow credit under subsection (4), (5) or (6) of this section or under ORS 731.511 only with respect to cessions of the kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in the state in which the assuming insurer is domiciled or, if the assuming insurer is an alien insurer, the state in which the assuming insurer is entered and is licensed or authorized to transact insurance or reinsurance. The director may allow credit under subsection (6) or (7) of this section only if the assuming insurer satisfies applicable requirements under subsection [*(10)*] **(11)** of this section.

(4) The director shall allow credit if the reinsurance is ceded to an authorized assuming insurer that accepts reinsurance of risks and retains the risk of the reinsurance within such limits as the assuming insurer is otherwise authorized to insure in this state, as provided in ORS 731.508.

(5) The director shall allow credit if 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 may not allow credit to a domestic ceding insurer if the director has revoked accreditation of the assuming insurer after notice and opportunity for hearing.

(6) The director shall allow credit if 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 the foreign assuming insurer's or the alien assuming insurer's books and records.

(7) The director shall allow credit if the reinsurance is ceded to an assuming insurer that maintains a trust fund meeting the requirements of this subsection and subsection (8) of this section and that also complies with other requirements of this subsection and subsection (8) of this section. 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 the assuming insurer's United States policyholders and ceding insurers and the assigns and successors in interest of the policyholders and ceding insurers. The assuming insurer must report annually to the director information that is sub-

stantially the same as information authorized insurers must report on the annual statement form under ORS 731.574, in order to enable the director to determine the sufficiency of the trust fund. The assuming insurer shall submit to the director's examination of the assuming insurer's books and records and shall pay to the director the expenses of the examination.

(8) The following requirements apply to the following categories of assuming insurers:

(a)(A) For 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, except as provided in subparagraph (B) of this paragraph, the assuming insurer must maintain a trusteed surplus of not less than $20,000,000.

(B) At any time after the assuming insurer permanently discontinues underwriting, for at least three full years, new business that the trust secures, the commissioner that has principal regulatory oversight over the trust may authorize a reduction in the required trusteed surplus, but only after finding based on an assessment of the risk that the new required surplus level is adequate to protect United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and must consider all material risk factors including, if applicable, the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The commissioner may not reduce the amount of the minimum required trusteed surplus below 30 percent of the assuming insurer's liabilities that are attributable to reinsurance that United States ceding insurers covered by the trust have ceded.

(b) For a group that includes 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 must consist of a trusteed account in an amount not less than the group's several liabilities attributable to business United States domiciled ceding insurers have ceded 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 must 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 must 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 may not engage in any business other than underwriting as a member of the group and are 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) For the 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 subsection (7) of this section and that has continuously transacted an insurance business outside the United States for at least three years immediately before applying 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 the group's 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 the member's independent certified public accountant.

(d) The form of the trust and any amendment to the trust must be 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 must 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 are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to the trust's assets in the trust's trustees for the benefit of the assuming insurer's United States ceding insurers and the assigns and successors in interest of the ceding insurers. 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, list the trust's investments at the preceding year end and certify the date of termination of the trust, if a termination is planned, or certify that the trust will not expire prior to the following December 31.

(9) The director shall allow credit if the reinsurance is ceded to an assuming insurer that does not meet the requirements of subsection (4), (5), (6) or (7) of this section or ORS 731.511 (1) or (4), 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.

(10) The director shall allow credit if the reinsurance is ceded to the Oregon Reinsurance Program established in section 18, chapter 538, Oregon Laws 2017.

[*(10)*] **(11)** If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this state, the director may not allow the credit permitted by subsections (6) and (7) of this section unless the assuming insurer agrees in the reinsurance agreement to the provisions stated in this subsection. This subsection does not conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate the parties' disputes, if such an obligation is created in the agreement. The assuming insurer must agree in the reinsurance agreement:

(a) That if the assuming insurer fails to perform the assuming insurer's 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 the assuming insurer's 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.

[*(11)*] **(12)** If the assuming insurer does not meet the requirements of subsection (4), (5) or (6) of this section or ORS 731.511 (1) or (4), the director may not allow the credit permitted by subsection (7) of this section 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 the trust fund contains an amount less than the applicable amount required by subsection (8)(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 must be distributed by and claims must 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 apply 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 of the assets is not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the insurance commissioner of the state in which the trust is domiciled shall return the assets or part of the assets in accordance with the laws of the state and the terms of the trust agreement that are consistent with the laws of the state.

(d) The grantor shall waive any right otherwise available to the grantor under United States law that is inconsistent with this subsection.

SECTION 4. ORS 731.509, as amended by section 3 of this 2025 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 the intent of the Legislative Assembly is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom insurers and reinsurers 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 the alien insurer's or reinsurer's United States obligations in accordance with ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the assets representing the security must be maintained in the United States and claims must be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets must 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 may 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 (4) of this section;

(b) Subsection (5) of this section and ORS 731.511 (1);

(c) Subsection (6) of this section;

(d) Subsections (7) and (8) of this section;

(e) ORS 731.511; **or**

(f)(A) Subsection (9) of this section; and

(B) Additional requirements that the director specifies by rule, which may include:

(i) The valuation of assets or reserve credits;

(ii) The amount and forms of security that support reinsurance arrangements; and

(iii) The circumstances under which the director will reduce or eliminate credit[*; or*]

[*(g) Subsection (10) of this section*].

(3) The director shall allow credit under subsection (4), (5) or (6) of this section or under ORS 731.511 only with respect to cessions of the kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in the state in which the assuming insurer is domiciled or, if the assuming insurer is an alien insurer, the state in which the assuming insurer is entered and is licensed or authorized to transact insurance or reinsurance. The director may allow credit under subsection (6) or (7) of this section only if the assuming insurer satisfies applicable requirements under subsection [*(11)*] **(10)** of this section.

(4) The director shall allow credit if the reinsurance is ceded to an authorized assuming insurer that accepts reinsurance of risks and retains the risk of the reinsurance within such limits as the assuming insurer is otherwise authorized to insure in this state, as provided in ORS 731.508.

(5) The director shall allow credit if 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 may not allow credit

to a domestic ceding insurer if the director has revoked accreditation of the assuming insurer after notice and opportunity for hearing.

(6) The director shall allow credit if 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 the foreign assuming insurer's or the alien assuming insurer's books and records.

(7) The director shall allow credit if the reinsurance is ceded to an assuming insurer that maintains a trust fund meeting the requirements of this subsection and subsection (8) of this section and that also complies with other requirements of this subsection and subsection (8) of this section. 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 the assuming insurer's United States policyholders and ceding insurers and the assigns and successors in interest of the policyholders and ceding insurers. The assuming insurer must report annually to the director information that is substantially the same as information authorized insurers must report on the annual statement form under ORS 731.574, in order to enable the director to determine the sufficiency of the trust fund. The assuming insurer shall submit to the director's examination of the assuming insurer's books and records and shall pay to the director the expenses of the examination.

(8) The following requirements apply to the following categories of assuming insurers:

(a)(A) For 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, except as provided in subparagraph (B) of this paragraph, the assuming insurer must maintain a trusteed surplus of not less than $20,000,000.

(B) At any time after the assuming insurer permanently discontinues underwriting, for at least three full years, new business that the trust secures, the commissioner that has principal regulatory oversight over the trust may authorize a reduction in the required trusteed surplus, but only after finding based on an assessment of the risk that the new required surplus level is adequate to protect United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and must consider all material risk factors including, if applicable, the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The commissioner may not reduce the amount of the minimum required trusteed surplus below 30 percent of the assuming insurer's liabilities that are attributable to reinsurance that United States ceding insurers covered by the trust have ceded.

(b) For a group that includes 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 must consist of a trusteed account in an amount not less than the group's several liabilities attributable to business United States domiciled ceding insurers have ceded 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 must 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 must 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 may not engage in any business other than underwriting as a member of the group and are 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) For the 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 subsection (7) of this section and that has continuously transacted an insurance business outside the United States for at least three years immediately before applying 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 the group's 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 the member's independent certified public accountant.

(d) The form of the trust and any amendment to the trust must be 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 must 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 are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to the trust's assets in the trust's trustees for the benefit of the assuming insurer's United States ceding insurers and the assigns and successors in interest of the ceding insurers. 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, list the trust's investments at the preceding year end and certify the date of termination of the trust, if a termination is planned, or certify that the trust will not expire prior to the following December 31.

(9) The director shall allow credit if the reinsurance is ceded to an assuming insurer that does not meet the requirements of subsection (4), (5), (6) or (7) of this section or ORS 731.511 (1) or (4), 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.

[*(10) The director shall allow credit if the reinsurance is ceded to the Oregon Reinsurance Program established in section 18, chapter 538, Oregon Laws 2017.*]

[*(11)*] **(10)** If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this state, the director may not allow the credit permitted by subsections (6) and (7) of this section unless the assuming insurer agrees in the reinsurance agreement to the provisions

stated in this subsection. This subsection does not conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate the parties' disputes, if such an obligation is created in the agreement. The assuming insurer must agree in the reinsurance agreement:

(a) That if the assuming insurer fails to perform the assuming insurer's 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 the assuming insurer's 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.

[*(12)*] **(11)** If the assuming insurer does not meet the requirements of subsection (4), (5) or (6) of this section or ORS 731.511 (1) or (4), the director may not allow the credit permitted by subsection (7) of this section 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 the trust fund contains an amount less than the applicable amount required by subsection (8)(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 must be distributed by and claims must 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 apply 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 of the assets is not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the insurance commissioner of the state in which the trust is domiciled shall return the assets or part of the assets in accordance with the laws of the state and the terms of the trust agreement that are consistent with the laws of the state.

(d) The grantor shall waive any right otherwise available to the grantor under United States law that is inconsistent with this subsection.

SECTION 5. Section 48, chapter 538, Oregon Laws 2017, as amended by section 3, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 48. Sections 18 to 22, chapter 538, Oregon Laws 2017, are repealed on January 2, [*2028*] **2038**.

SECTION 6. (1) Section 2, chapter 538, Oregon Laws 2017, is repealed on January 2, 2038.

(2) Section 3, chapter 538, Oregon Laws 2017, as amended by section 4, chapter 2, Oregon Laws 2019, is repealed on January 2, 2038.

(3) Section 4, chapter 538, Oregon Laws 2017, as amended by section 5, chapter 2, Oregon Laws 2019, and section 1 of this 2025 Act, is repealed on January 2, 2038.

(4) Section 5, chapter 538, Oregon Laws 2017, as amended by section 6, chapter 2, Oregon Laws 2019, is repealed on January 2, 2038.

(5) Section 6, chapter 538, Oregon Laws 2017, as amended by section 7, chapter 2, Oregon Laws 2019, is repealed on January 2, 2038.

(6) Section 7, chapter 538, Oregon Laws 2017, is repealed on January 2, 2038.

(7) Section 8, chapter 538, Oregon Laws 2017, as amended by section 8, chapter 2, Oregon Laws 2019, and section 2 of this 2025 Act, is repealed on January 2, 2038.

SECTION 7. Nothing in the repeal of sections 2 to 8, chapter 538, Oregon Laws 2017, by section 6 of this 2025 Act affects the imposition and collection of a health insurance premium

assessment under section 3 or 5, chapter 538, Oregon Laws 2017, for a calendar quarter ending on or before December 31, 2032.

SECTION 8. Any moneys remaining in the Health System Fund established by section 2, chapter 538, Oregon Laws 2017, on December 31, 2038, are transferred to the General Fund.

MANAGED CARE ORGANIZATION ASSESSMENT

SECTION 9. ORS 414.884 is amended to read:

414.884. ORS 414.880, 414.882 and 414.902 apply to any payments made to a managed care organization by the Oregon Health Authority for the period beginning January 1, 2020, and ending December 31, [*2026*] **2032**.

SECTION 10. ORS 414.880, 414.882, 414.884 and 414.902 are repealed on January 2, 2038.

SECTION 11. Nothing in the repeal of ORS 414.880, 414.882, 414.884 and 414.902 by section 10 of this 2025 Act affects the imposition and collection of a managed care organization assessment under ORS 414.880 for a calendar quarter ending on or before December 31, 2032.

HOSPITAL ASSESSMENT

SECTION 11a. ORS 414.853 is amended to read:

414.853. As used in ORS 414.853 to 414.869 and 414.900:

(1) "Charity care" means costs for providing inpatient or outpatient care services free of charge or at a reduced charge because of the indigence or lack of health insurance of the patient receiving the care services.

(2) "Contractual adjustments" means the difference between the amounts charged based on the hospital's full established charges and the amount received or due from the payor.

(3)(a) "Hospital" means a hospital licensed under ORS chapter 441.

(b) "Hospital" does not include:

(A) Special inpatient care facilities;

(B) Hospitals that provide only psychiatric care;

(C) Pediatric specialty hospitals providing care to children at no charge; and

(D) Public hospitals other than hospitals created by health districts under ORS 440.315 to 440.410.

(4) "Net **inpatient** revenue":

(a) Means the total amount of charges for inpatient [*or outpatient*] care provided by the hospital to patients, less charity care, bad debts and contractual adjustments;

(b) Does not include revenue derived from sources other than inpatient [*or outpatient*] operations, including but not limited to interest and guest meals; and

(c) Does not include any revenue that is taken into account in computing a long term care facility assessment under ORS 409.800 to 409.816 and 409.900.

(5) "Net outpatient revenue":

(a) Means the total amount of charges for outpatient care provided by the hospital to patients, less charity care, bad debts and contractual adjustments;

(b) Does not include revenue derived from sources other than outpatient operations, including but not limited to interest and guest meals; and

(c) Does not include any revenue that is taken into account in computing a long term care facility assessment under ORS 409.800 to 409.816 and 409.900.

[*(5)*] **(6)** "Type A hospital" has the meaning given that term in ORS 442.470.

[*(6)*] **(7)** "Type B hospital" has the meaning given that term in ORS 442.470.

SECTION 11b. ORS 414.855 is amended to read:

414.855. (1) An assessment is imposed on the net **inpatient** revenue **and net outpatient revenue** of each hospital in this state. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate

needed to fund the services and costs identified in ORS 414.869. The rate of assessment shall be imposed on the net **inpatient** revenue **and net outpatient revenue** of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

(2) Each assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the 45th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection (5) of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

(3)(a) To the extent permitted by federal law, aggregate assessments imposed under this section may not exceed the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

(A) 30 percent of payments made to the hospitals on a fee-for-service basis by the authority for inpatient hospital services;

(B) 41 percent of payments made to the hospitals on a fee-for-service basis by the authority for outpatient hospital services; and

(C) Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.570 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed under this section on or after July 1, 2015, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for hospital services under ORS 414.591, 414.631 and 414.688 to 414.745.

(c) The director may impose a lower rate of assessment on type A hospitals and type B hospitals to take into account the hospitals' financial position.

(d) The director may adopt different rates of assessment for net inpatient revenue and net outpatient revenue.

(4) Notwithstanding subsection (3) of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

(5)(a) The authority shall develop a schedule for collection of the assessment for [*the*] **each** calendar quarter [*ending September 30, 2021, that will result in the collection occurring between December 15, 2021, and the time all Medicaid cost settlements are finalized for that calendar quarter*].

(b) The authority shall prescribe by rule criteria for late payment of assessments.

SECTION 11c. ORS 414.871 is amended to read:

414.871. ORS 414.853 to 414.869 and 414.900 apply to net **inpatient** revenues **and net outpatient revenues** earned by hospitals during a period beginning July 1, 2019, and ending the earlier of [*September 30, 2025*] **December 31, 2032**, 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 12. 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, section 38, chapter 538, Oregon Laws 2017, and section 14, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 12. (1) [*Sections 1 to 9, chapter 736, Oregon Laws 2003,*] **ORS 414.853, 414.855, 414.857, 414.863, 414.865, 414.867, 414.869 and 414.900 and section 4, chapter 736, Oregon Laws 2003,** are repealed on January 2, [*2031*] **2038**.

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

SECTION 13. ORS 414.871 is repealed on January 2, 2038.

SECTION 14. 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, section 39, chapter 538, Oregon Laws 2017, and section 15, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 13. Nothing in the repeal of [*sections 1 to 9, chapter 736, Oregon Laws 2003,*] **ORS 414.853, 414.855, 414.857, 414.863, 414.865, 414.867, 414.869 and 414.900 and section 4, 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,*] **ORS 414.853, 414.855, 414.857, 414.863, 414.865, 414.867, 414.869 and 414.900 and section 4, chapter 736, Oregon Laws 2003,** for a calendar quarter [*beginning before September 30, 2025*] **ending on or before December 31, 2032**.

SECTION 15. 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, section 40, chapter 538, Oregon Laws 2017, and section 16, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 14. Any moneys remaining in the Hospital Quality Assurance Fund on December 31, [*2031*] **2038**, are transferred to the General Fund.

OREGON HEALTH AND SCIENCE UNIVERSITY REIMBURSEMENT

SECTION 15a. Section 19, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 19. (1) The amendments to section 41, chapter 538, Oregon Laws 2017, by section 17**, chapter 2, Oregon Laws 2019,** [*of this 2019 Act*] apply to reimbursement paid to the Oregon Health and Science University by the Oregon Health Authority on or after July 1, 2019, but before July 1, [*2025*] **2032**.

(2) The amendments to section 41, chapter 538, Oregon Laws 2017, by section 18**, chapter 2, Oregon Laws 2019,** [*of this 2019 Act*] apply to reimbursement paid to the university by the authority on or after July 1, [*2025*] **2032**.

CONFORMING AMENDMENTS

SECTION 16. ORS 731.292 is amended to read:

731.292. (1) Except as provided in subsections (2), (3) and (4) of this section, all fees, charges and other moneys received by the Department of Consumer and Business Services or the Director of the Department of Consumer and Business Services under the Insurance Code shall be deposited in the fund created by ORS 705.145 and are continuously appropriated to the department for the payment of the expenses of the department in carrying out the Insurance Code.

(2) All taxes and penalties paid pursuant to the Insurance Code shall be paid to the director and after deductions of refunds shall be paid by the director to the State Treasurer, at the end of every calendar month or more often in the director's discretion, for deposit in the General Fund to become available for general governmental expenses.

(3) All premium taxes received by the director pursuant to ORS 731.820 shall be paid by the director to the State Treasurer for deposit in the State Fire Marshal Fund.

[*(4) Assessments received by the department under sections 3 and 5, chapter 538, Oregon Laws 2017, and penalties received by the department under section 6, chapter 538, Oregon Laws 2017, shall be paid into the State Treasury and credited to the Health System Fund established under section 2, chapter 538, Oregon Laws 2017.*]

SECTION 17. ORS 731.840 is amended to read:

731.840. (1) The retaliatory tax imposed upon a foreign or alien insurer under ORS 731.854 and 731.859, or the corporate excise tax imposed upon a foreign or alien insurer under ORS chapter 317, is in lieu of all other state taxes upon premiums, taxes upon income, franchise or other taxes measured by income that might otherwise be imposed upon the foreign or alien insurer except the fire insurance premiums tax imposed under ORS 731.820[,] **and** the tax imposed upon wet marine and transportation insurers under ORS 731.824 and 731.828 [*and the assessment imposed under section 5, chapter 538, Oregon Laws 2017*]. However, all real and personal property, if any, of the insurer shall

be listed, assessed and taxed the same as real and personal property of like character of noninsurers. Nothing in this subsection shall be construed to preclude the imposition of the assessments imposed under ORS 656.612 upon a foreign or alien insurer.

(2) Subsection (1) of this section applies to a reciprocal insurer and its attorney in its capacity as such.

(3) Subsection (1) of this section applies to foreign or alien title insurers and to foreign or alien wet marine and transportation insurers issuing policies and subject to taxes referred to in ORS 731.824 and 731.828.

(4) The State of Oregon hereby preempts the field of regulating or of imposing excise, privilege, franchise, income, license, permit, registration, and similar taxes, licenses and fees upon insurers and their insurance producers and other representatives as such, and:

(a) No county, city, district, or other political subdivision or agency in this state shall so regulate, or shall levy upon insurers, or upon their insurance producers and representatives as such, any such tax, license or fee; except that whenever a county, city, district or other political subdivision levies or imposes generally on a nondiscriminatory basis throughout the jurisdiction of the taxing authority a payroll, excise or income tax, as otherwise provided by law, such tax may be levied or imposed upon domestic insurers; and

(b) No county, city, district, political subdivision or agency in this state shall require of any insurer, insurance producer or representative, duly authorized or licensed as such under the Insurance Code, any additional authorization, license, or permit of any kind for conducting therein transactions otherwise lawful under the authority or license granted under this code.

SECTION 18. 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 a public university 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 pursuant to ORS 408.362 and 408.365 to 408.385 and by other state agencies and institutions pursuant to ORS 179.610 to 179.770.

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

[*(C) Assessments paid to the Department of Consumer and Business Services under sections 3 and 5, chapter 538, Oregon Laws 2017.*]

(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 456.595 and 469.421 (8).

(i) Assessments on premiums charged by the Director of the Department of Consumer and Business Services pursuant to ORS 731.804 or fees charged by the director to banks, trusts and credit unions pursuant to ORS 706.530 and 723.114.

(j) 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.

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

(L) 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.

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

(n) Portal provider fees as defined in ORS 276A.270 and established by the State Chief Information Officer under ORS 276A.276 (3) and recommended by the Electronic Government Portal Advisory Board.

(o) Fees set by the State Parks and Recreation Director and approved by the State Parks and Recreation Commission under ORS 390.124 (2)(b).

(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 19. ORS 243.135 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. The board shall impose a surcharge in an amount determined by the board on an eligible employee who arranges coverage for the employee's spouse or dependent under this subsection if the spouse or dependent has access to medical coverage as an employee in another health benefit plan offered by the board or the Oregon Educators Benefit Board.

(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) As frequently as is recommended as a commercial best practice by consultants engaged by the board, the board shall 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.

SECTION 20. ORS 317A.100, as amended by section 26, chapter 75, Oregon Laws 2024, is amended to read:

317A.100. As used in ORS 317A.100 to 317A.158:

(1)(a) "Commercial activity" means:

(A) The total amount realized by a person, arising from transactions and activity in the regular course of the person's trade or business, without deduction for expenses incurred by the trade or business;

(B) If received by a financial institution:

(i) If the reporting person for a financial institution is a holding company, all items of income reported on the FR Y-9 filed by the holding company;

(ii) If the reporting person for a financial institution is a bank organization, all items of income reported on the call report filed by the bank organization; and

(iii) If the reporting person for a financial institution is a nonbank financial organization, all items of income reported in accordance with generally accepted accounting principles; and

(C)(i) If received by an insurer, as reported on the statement of premiums accompanying the annual statement required under ORS 731.574 to be filed with the Director of the Department of Consumer and Business Services, all gross direct life insurance premiums, gross direct accident and health insurance premiums and gross direct property and casualty insurance premiums; and

(ii) The gross amount of surplus lines premiums received on Oregon home state risks as shown in the report required by ORS 735.465.

(b) "Commercial activity" does not include:

(A) Interest income except:

(i) Interest on credit sales; or

(ii) Interest income, including service charges, received by financial institutions;

(B) Receipts from the sale, exchange or other disposition of an asset described in section 1221 or 1231 of the Internal Revenue Code, without regard to the length of time the person held the asset;

(C) If received by an insurer, federally reinsured premiums or income from transactions between a reciprocal insurer and its attorney in fact operating under ORS 731.142;

(D) Receipts from hedging transactions, to the extent that the transactions are entered into primarily to protect a financial position, including transactions intended to manage the risk of exposure to foreign currency fluctuations that affect assets, liabilities, profits, losses, equity or investments in foreign operations, risk of exposure to interest rate fluctuations or risk of commodity price fluctuations;

(E) Proceeds received attributable to the repayment, maturity or redemption of the principal of a loan, bond, mutual fund, certificate of deposit or marketable instrument;

(F) The principal amount received under a repurchase agreement or on account of any transaction properly characterized as a loan to the person;

(G) Contributions received by a trust, plan or other arrangement, any of which is described in section 501(a) of the Internal Revenue Code, or to which title 26, subtitle A, chapter 1, subchapter (D) of the Internal Revenue Code applies;

(H) Compensation, whether current or deferred, and whether in cash or in kind, received or to be received by an employee, a former employee or the employee's legal successor for services rendered to or for an employer, including reimbursements received by or for an individual for medical or education expenses, health insurance premiums or employee expenses or on account of a dependent care spending account, legal services plan, any cafeteria plan described in section 125 of the Internal Revenue Code or any similar employee reimbursement;

(I) Proceeds received from the issuance of the taxpayer's own stock, options, warrants, puts or calls, or from the sale of the taxpayer's treasury stock;

(J) Proceeds received on the account of payments from insurance policies, including crop insurance policies, owned by the taxpayer, except those proceeds received for the loss of commercial activity;

(K) Gifts or charitable contributions received, membership dues received by trade, professional, homeowners' or condominium associations, payments received for educational courses, meetings or meals, or similar payments to a trade, professional or other similar association, and fundraising receipts received by any person when any excess receipts are donated or used exclusively for charitable purposes;

(L) Damages received as the result of litigation in excess of amounts that, if received without litigation, would be treated as commercial activity;

(M) Property, money and other amounts received or acquired by an agent on behalf of another in excess of the agent's commission, fee or other remuneration;

(N) Tax refunds from any tax program, other tax benefit recoveries and reimbursements for the tax imposed under ORS 317A.100 to 317A.158 made by entities that are part of the same unitary group as provided under ORS 317A.106, and reimbursements made by entities that are not members of a unitary group that are required to be made for economic parity among multiple owners of an

entity whose tax obligation under ORS 317A.100 to 317A.158 is required to be reported and paid entirely by one owner, as provided in ORS 317A.106;

(O) Pension reversions;

(P) Contributions to capital;

(Q) Receipts from the sale, transfer, exchange or other disposition of motor vehicle fuel or any other product used for the propulsion of motor vehicles;

(R) In the case of receipts from the sale of cigarettes or tobacco products by a wholesale dealer, retail dealer, distributor, manufacturer or seller, an amount equal to the federal and state excise taxes paid by any person on or for such cigarettes or tobacco products under subtitle E of the Internal Revenue Code or ORS chapter 323;

(S) In the case of receipts from the sale of malt beverages or wine, as defined in ORS 471.001, cider, as defined in ORS 471.023 or distilled liquor, as defined in ORS 471.001, by a person holding a license issued under ORS chapter 471, an amount equal to the federal and state excise taxes paid by any person on or for such malt beverages, wine or distilled liquor under subtitle E of the Internal Revenue Code or ORS chapter 471 or 473, and any amount paid to the Oregon Liquor and Cannabis Commission for sales of distilled spirits by an agent appointed under ORS 471.750;

(T) In the case of receipts from the sale of marijuana items, as defined in ORS 475C.009, by a person holding a license issued under ORS 475C.005 to 475C.525, an amount equal to the federal and state excise taxes paid by any person on or for such marijuana items under subtitle E of the Internal Revenue Code or ORS 475C.670 to 475C.734 and any local retail taxes authorized under ORS 475C.453;

(U) Local taxes collected by a restaurant or other food establishment on sales of meals, prepared food or beverages;

(V) Tips or gratuities collected by a restaurant or other food establishment and passed on to employees;

(W) Receipts realized by a vehicle dealer certified under ORS 822.020 or a person described in ORS 320.400 (8)(a)(B) from the sale or other transfer of a motor vehicle, as defined in ORS 801.360, to another vehicle dealer for the purpose of resale by the transferee vehicle dealer, but only if the sale or other transfer was based upon the transferee's need to meet a specific customer's preference for a motor vehicle or is an exchange of new vehicles between franchised motor vehicle dealerships;

(X) Registration fees or taxes collected by a vehicle dealer certified under ORS 822.020 or a person described in ORS 320.400 (8)(a)(B) at the sale or other transfer of a motor vehicle, as defined in ORS 801.360, that are owed to a third party by the purchaser of the motor vehicle and passed to the third party by the dealer;

(Y) Receipts from a financial institution for services provided to the financial institution in connection with the issuance, processing, servicing and management of loans or credit accounts, if the financial institution and the recipient of the receipts have at least 50 percent of their ownership interests owned or controlled, directly or constructively through related interests, by common owners;

(Z) In the case of amounts retained as commissions by a holder of a license under ORS chapter 462, an amount equal to the amounts specified under ORS chapter 462 that must be paid to or collected by the Department of Revenue as a tax and the amounts specified under ORS chapter 462 to be used as purse money;

(AA) Receipts of residential care facilities as defined in ORS 443.400 or in-home care agencies as defined in ORS 443.305, to the extent that the receipts are derived from or received as compensation for providing services to a medical assistance or Medicare recipient;

(BB) Dividends received;

(CC) Distributive income received from a pass-through entity;

(DD) Receipts from sales to a wholesaler in this state, if the seller receives certification at the time of sale from the wholesaler that the wholesaler will sell the purchased property outside this state;

(EE) Receipts from the wholesale or retail sale of groceries, including receipts of a person that owns groceries at the time of sale and compensation of any consignee engaged in effecting the sale of groceries on behalf the owner of the groceries, but only to the extent that the compensation relates to grocery sales;

(FF) Receipts from transactions among members of a unitary group;

(GG) Moneys, including public purpose charge moneys collected under ORS 757.612 and moneys collected to plan for and pursue cost-effective energy efficiency resources under ORS 757.054, that are collected from customers, passed to a utility and approved by the Public Utility Commission and that support energy conservation, renewable resource acquisition and low-income assistance programs;

(HH) Moneys collected by a utility from customers for the payment of loans through on-bill financing;

(II) Surcharges collected under ORS 757.736;

(JJ) Moneys passed to a utility by the Bonneville Power Administration for the purpose of effectuating the Regional Power Act Exchange credits or pursuant to any settlement associated with the exchange credit;

(KK) Moneys collected or recovered, by entities listed in ORS 756.310, cable operators as defined in 47 U.S.C. 522(5), telecommunications carriers as defined in 47 U.S.C. 153(51) and providers of information services as defined in 47 U.S.C. 153(24), for fees payable under ORS 756.310, right-of-way fees, franchise fees, privilege taxes, federal taxes and local taxes;

(LL) Charges paid to the Residential Service Protection Fund required by chapter 290, Oregon Laws 1987;

(MM) Universal service surcharge moneys collected or recovered and paid into the universal service fund established in ORS 759.425;

(NN) Moneys collected for public purpose funding as described in ORS 759.430;

(OO) Moneys collected or recovered and paid into the federal universal service fund as determined by the Federal Communications Commission;

(PP) In the case of a seller or provider of telecommunications services, the amount of tax imposed under ORS 403.200 for access to the emergency communications system that is collected from subscribers or consumers;

(QQ) In the case of a transient lodging tax collector, the amount of tax imposed under ORS 320.305 and of any local transient lodging tax imposed upon the occupancy of transit lodging;

(RR) In the case of a seller of bicycles, the amount of tax imposed under ORS 320.415 upon retail sales of bicycles;

(SS) In the case of a qualified heavy equipment provider, the amount of tax imposed under ORS 307.872 upon the rental price of heavy equipment;

(TT) Farmer sales to an agricultural cooperative in this state that is a cooperative organization described in section 1381 of the Internal Revenue Code;

(UU) Revenue received by a business entity that is mandated by contract or subcontract to be distributed to another person or entity if the revenue constitutes sales commissions that are paid to a person who is not an employee of the business entity, including, without limitation, a split-fee real estate commission;

(VV) Receipts from the sale of fluid milk by dairy farmers that are not members of an agricultural cooperative; and

(WW)(i) Cost paid by a dealer for items of precious metal.

(ii) As used in this subparagraph, "item of precious metal" means an item of gold, silver, platinum, rhodium or palladium that has been put through a process of smelting or refining and that is in a state or condition that its value depends on its contents and not its form.

(2) "Cost inputs" means:

(a) The cost of goods sold as calculated in arriving at federal taxable income under the Internal Revenue Code; or

(b) In the case of a taxpayer that is engaged in a farming operation, as defined in ORS 317A.102, and that does not report cost of goods sold for federal tax purposes, the taxpayer's operating expenses excluding labor costs.

(3) "Doing business" means engaging in any activity, whether legal or illegal, that is conducted for, or results in, the receipt of commercial activity at any time during a calendar year.

(4) "Excluded person" means any of the following:

(a) Organizations described in sections 501(c) and 501(j) of the Internal Revenue Code, unless the exemption is denied under section 501(h), (i) or (m) or under section 502, 503 or 505 of the Internal Revenue Code.

(b) Organizations described in section 501(d) of the Internal Revenue Code, unless the exemption is denied under section 502 or 503 of the Internal Revenue Code.

(c) Organizations described in section 501(e) of the Internal Revenue Code.

(d) Organizations described in section 501(f) of the Internal Revenue Code.

(e) Charitable risk pools described in section 501(n) of the Internal Revenue Code.

(f) Organizations described in section 521 of the Internal Revenue Code.

(g) Qualified state tuition programs described in section 529 of the Internal Revenue Code.

(h) Foreign or alien insurance companies, but only with respect to the underwriting profit derived from writing wet marine and transportation insurance subject to tax under ORS 731.824 and 731.828 or if an insurance company is subject to the retaliatory tax under ORS 731.854 and 731.859.

(i) Governmental entities.

(j) Any person with commercial activity that does not exceed $750,000 for the tax year, other than a person that is part of a unitary group as provided in ORS 317A.106 with commercial activity in excess of $750,000.

(k) [*Hospitals subject to assessment under ORS 414.855,*] Long term care facilities subject to assessment under ORS 409.801 [*or any entity subject to assessment under ORS 414.880 or section 3 or 5, chapter 538, Oregon Laws 2017*].

(L) Manufactured dwelling park nonprofit cooperatives organized under ORS chapter 62.

(5) "Financial institution" has the meaning given that term in ORS 314.610, except that "financial institution" does not include a credit union.

(6)(a) "FR Y-9" means the consolidated or parent-only financial statements that a holding company is required to file with the Federal Reserve Board pursuant to 12 U.S.C. 1844.

(b) In the case of a holding company required to file both consolidated and parent-only financial statements, "FR Y-9" means the consolidated financial statements that the holding company is required to file.

(7) "Governmental entity" means:

(a) The United States and any of its unincorporated agencies and instrumentalities.

(b) Any incorporated agency or instrumentality of the United States wholly owned by the United States or by a corporation wholly owned by the United States.

(c) The State of Oregon and any of its unincorporated agencies and instrumentalities.

(d) Any county, city, district or other political subdivision of the state.

(e) A special government body as defined in ORS 174.117.

(f) A federally recognized Indian tribe.

(8) "Groceries" means food as defined in 7 U.S.C. 2012(k), but does not include cannabinoid edibles or marijuana seeds.

(9)(a) "Hedging transaction" means a hedging transaction as defined in section 1221 of the Internal Revenue Code or a transaction accorded hedge accounting treatment under Financial Accounting Standards Board Statement No. 133.

(b) "Hedging transaction" does not include a transaction in which an actual transfer of title of real or tangible property to another entity occurs.

(10) "Insurer" has the meaning given that term in ORS 317.010.

(11) "Internal Revenue Code," except where the Legislative Assembly has provided otherwise, refers to the laws of the United States or to the Internal Revenue Code as they are amended and in effect on December 31, 2023.

(12) "Labor costs" means total compensation of all employees, not to include compensation paid to any single employee in excess of $500,000.

(13)(a) "Motor vehicle fuel or any other product used for the propulsion of motor vehicles" means:

(A) Motor vehicle fuel as defined in ORS 319.010; and

(B) Fuel the use of which in a motor vehicle is subject to taxation under ORS 319.530.

(b) "Motor vehicle fuel or any other product used for the propulsion of motor vehicles" does not mean:

(A) Electricity; or

(B) Electric batteries or any other mechanical or physical component or accessory of a motor vehicle.

(14) "Person" includes individuals, combinations of individuals of any form, receivers, assignees, trustees in bankruptcy, firms, companies, joint-stock companies, business trusts, estates, partnerships, limited liability partnerships, limited liability companies, associations, joint ventures, clubs, societies, entities organized as for-profit corporations under ORS chapter 60, C corporations, S corporations, qualified subchapter S subsidiaries, qualified subchapter S trusts, trusts, entities that are disregarded for federal income tax purposes and any other entities.

(15) "Retailer" means a person doing business by selling tangible personal property to a purchaser for a purpose other than:

(a) Resale by the purchaser of the property as tangible personal property in the regular course of business;

(b) Incorporation by the purchaser of the property in the course of regular business as an ingredient or component of real or personal property; or

(c) Consumption by the purchaser of the property in the production for sale of a new article of tangible personal property.

(16) "Taxable commercial activity" means commercial activity sourced to this state under ORS 317A.128, less any subtraction pursuant to ORS 317A.119.

(17)(a) "Taxpayer" means any person or unitary group required to register, file or pay tax under ORS 317A.100 to 317A.158.

(b) "Taxpayer" does not include excluded persons, except to the extent that a tax-exempt entity has unrelated business income as described in the Internal Revenue Code.

(18) "Tax year" means, except as otherwise provided in ORS 317A.103, a taxpayer's annual accounting period used for federal income tax purposes under section 441 of the Internal Revenue Code.

(19)(a) "Unitary business" means a business enterprise in which there exists directly or indirectly between the members or parts of the enterprise a sharing or exchange of value as demonstrated by:

(A) Centralized management or a common executive force;

(B) Centralized administrative services or functions resulting in economies of scale; or

(C) Flow of goods, capital resources or services demonstrating functional integration.

(b) "Unitary business" may include a business enterprise the activities of which:

(A) Are in the same general line of business, such as manufacturing, wholesaling or retailing; or

(B) Constitute steps in a vertically integrated process, such as the steps involved in the production of natural resources, which might include exploration, mining, refining and marketing.

(20) "Unitary group" means a group of persons with more than 50 percent common ownership, either direct or indirect, that is engaged in business activities that constitute a unitary business.

(21) "Wholesaler" means a person primarily doing business by merchant distribution of tangible personal property to retailers or to other wholesalers.

SECTION 21. ORS 415.500 is amended to read:

415.500. As used in this section and ORS 415.501 and 415.505:

(1) "Corporate affiliation" has the meaning prescribed by the Oregon Health Authority by rule, including:

(a) Any relationship between two organizations that reflects, directly or indirectly, a partial or complete controlling interest or partial or complete corporate control; and

(b) Transactions that merge tax identification numbers or corporate governance.

(2) "Essential services" means:

(a) Services that are funded on the prioritized list described in ORS 414.690; and

(b) Services that are essential to achieve health equity.

(3) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(4)(a) "Health care entity" includes:

(A) An individual health professional licensed or certified in this state;

(B) A hospital, as defined in ORS 442.015, or hospital system, as defined by the authority by rule;

(C) A carrier, as defined in ORS 743B.005, that offers a health benefit plan in this state;

(D) A Medicare Advantage plan;

(E) A coordinated care organization or a prepaid managed care health services organization, as both terms are defined in ORS 414.025; and

(F) Any other entity that has as a primary function the provision of health care items or services or that is a parent organization of, or is an entity closely related to, an entity that has as a primary function the provision of health care items or services.

(b) "Health care entity" does not include:

(A) Long term care facilities, as defined in ORS 442.015.

(B) Facilities licensed and operated under ORS 443.400 to 443.455.

(5) "Health equity" has the meaning prescribed by the Oregon Health Policy Board and adopted by the authority by rule.

(6)(a) "Material change transaction" means:

(A) A transaction in which at least one party had average revenue of $25 million or more in the preceding three fiscal years and another party:

(i) Had an average revenue of at least $10 million in the preceding three fiscal years; or

(ii) In the case of a new entity, is projected to have at least $10 million in revenue in the first full year of operation at normal levels of utilization or operation as prescribed by the authority by rule.

(B) If a transaction involves a health care entity in this state and an out-of-state entity, a transaction that otherwise qualifies as a material change transaction under this paragraph that may result in increases in the price of health care or limit access to health care services in this state.

(b) "Material change transaction" does not include:

(A) A clinical affiliation of health care entities formed for the purpose of collaborating on clinical trials or graduate medical education programs.

(B) A medical services contract or an extension of a medical services contract.

(C) An affiliation that:

(i) Does not impact the corporate leadership, governance or control of an entity; and

(ii) Is necessary, as prescribed by the authority by rule, to adopt advanced value-based payment methodologies to meet the health care cost growth targets under ORS 442.386.

(D) Contracts under which one health care entity, for and on behalf of a second health care entity, provides patient care and services or provides administrative services relating to, supporting or facilitating the provision of patient care and services, if the second health care entity:

(i) Maintains responsibility, oversight and control over the patient care and services; and

(ii) Bills and receives reimbursement for the patient care and services.

(E) Transactions in which a participant that is a health center as defined in 42 U.S.C. 254b, while meeting all of the participant's obligations, acquires, affiliates with, partners with or enters

into any agreement with another entity unless the transaction would result in the participant no longer qualifying as a health center under 42 U.S.C. 254b.

(7)(a) "Medical services contract" means a contract to provide medical or mental health services entered into by:

(A) A carrier and an independent practice association;

(B) A carrier, coordinated care organization, independent practice association or network of providers and one or more providers, as defined in ORS 743B.001;

(C) An independent practice association and an individual health professional or an organization of health care providers;

(D) Medical, dental, vision or mental health clinics; or

(E) A medical, dental, vision or mental health clinic and an individual health professional to provide medical, dental, vision or mental health services.

(b) "Medical services contract" does not include a contract of employment or a contract creating a legal entity and ownership of the legal entity that is authorized under ORS chapter 58, 60 or 70 or under any other law authorizing the creation of a professional organization similar to those authorized by ORS chapter 58, 60 or 70, as may be prescribed by the authority by rule.

(8) "Net patient revenue" means the total amount of revenue, after allowance for contractual amounts, charity care and bad debt, received for patient care and services, including:

(a) Value-based payments;

(b) Incentive payments; **and**

(c) Capitation payments or payments under any similar contractual arrangement for the prepayment or reimbursement of patient care and services[*; and*]

[*(d) Any payment received by a hospital to reimburse a hospital assessment under ORS 414.855*].

(9) "Revenue" means:

(a) Net patient revenue; or

(b) The gross amount of premiums received by a health care entity that are derived from health benefit plans.

(10) "Transaction" means:

(a) A merger of a health care entity with another entity;

(b) An acquisition of one or more health care entities by another entity;

(c) New contracts, new clinical affiliations and new contracting affiliations that will eliminate or significantly reduce, as defined by the authority by rule, essential services;

(d) A corporate affiliation involving at least one health care entity; or

(e) Transactions to form a new partnership, joint venture, accountable care organization, parent organization or management services organization, as prescribed by the authority by rule.

CAPTIONS

SECTION 22. The unit captions used in this 2025 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 2025 Act.

OPERATIVE DATE AND EFFECTIVE DATE

SECTION 23. The amendments to ORS 243.135, 291.055, 317A.100, 415.500, 731.292, 731.509 and 731.840 by sections 4 and 16 to 21 of this 2025 Act become operative on January 2, 2038.

SECTION 24. This 2025 Act takes effect on the 91st day after the date on which the 2025 regular session of the Eighty-third Legislative Assembly adjourns sine die.

Passed by House February 27, 2025

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Julie Fahey, Speaker of House

Passed by Senate March 17, 2025

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2025

Approved:

.....M.,....., 2025

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2025

.....
Tobias Read, Secretary of State