Oregon Health Insurance Marketplace
Advisory Committee Meeting
June 26, 2026
9:35 – 10:55 a.m.

Virtual
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Phone: 971-277-2343
Meeting ID: 220 444 743 869 10
Passcode: GB9U24Ky

AGENDA

Time	Agenda Item	Facilitators and Presenters
9:35 – 9:40 a.m.	Welcome, meeting guidelines, and approval of April minutes	Nashoba Temperly Interim Committee Chair
9:40 – 9:55 a.m.	Overview of the Marketplace Assessment and Upcoming Changes	Chiqui Flowers Marketplace Director
9:55 – 10:40 a.m.	Proposed 2027 Marketplace assessment analysis	Caleb Lavan Senior Manager Myers and Stauffer
10:40 – 10:45 a.m.	Public comment	Nashoba Temperly Interim Committee Chair
10:45 – 10:50 a.m.	Next steps and voting	Victor Garcia Marketplace Operations Advisor and Program Liaison
10:50 – 10:55 a.m.	Wrap up and closing	Nashoba Temperly Interim Committee Chair

Everyone is welcome to join Health Insurance Marketplace Advisory Committee (HIMAC) meetings. For accessibility questions or requests, please contact dawn.a.shaw@oha.oregon.gov or call 503-951-3947 at least 3 business days prior to the meeting.

Please note that this public meeting will be recorded and transcribed.

Health Policy and Analytics

Oregon Health Insurance Marketplace

Tina Kotek, Governor

Health Insurance Marketplace Advisory Committee Meeting Minutes

DRAFT

When: Thursday, April 16, 2026 – 9:05 a.m. to 1:00 p.m.
Where: Virtual via Microsoft Teams
In-person at the Barbara Roberts Human Services Building
500 Summer St NE Rms 137A-D, Salem OR 97301

Committee members:
In-person – Stacy Carmichael, Charlie Fisher, Paul Harmon, Kathleen Orrick, Clare Pierce-Wrobel, Om Sukheenai, Nashoba Temperly (vice chair), Matthew Woodbridge, Alena Zbirun

Virtual – Ron Gallinat Lindsey Hopper (chair), TK Keen

Members not present: Marin Arreola

Other presenters and partners: Claire Houterman, Bill Kramer, David Simnitt, Jason Sparks

Marketplace staff: Katie Button, Amy Coven, Chiqui Flowers (director), Victor Garcia, Richard Krummel, Albert Salinas, Dawn Shaw, Jeff Wilcox

Agenda item and time stamp*	Discussion

Welcome, roll call, guidelines, approval of minutes	Roll call of Health Insurance Marketplace Advisory Committee (HIMAC) members, review of meeting guidelines, and approval of the February 19 meeting minutes. (See the handout packet pages 1-2 for a copy of the agenda, pages 3-6 for February minutes, and page 7 for meeting protocols.)
	• Approved February 19, 2026, minutes.
	  ○ First motion to approve – Nashoba Temperly
	  ○ Second motion to approve – Om Sukheenai
	  ○ Ayes – Stacy Carmichael, Paul Harmon, Lindsey Hopper, TK Keen, Clare Pierce-Wrobel, Om Sukheenai, Alena Zbirun
	  ○ Nays – none
	  ○ Absent – Marin Arreola, Charlie Fisher, Ron Gallinat, Kathleen Orrick

SBM project updates
7:00
	Presenters: Victor Garcia, Marketplace Operations Advisor and Program Liaison; Chiqui Flowers, Marketplace Director; Albert Salinas, Richard Krummel SBM Technical Team Managers; GetInsured Team – Jason Sparks & Claire Houterman; and Jeff Wilcox Marketplace Training Coordinator
	(See pages 8-10 of the handout packet for a copy of the slides.)
	• Marketplace Training – how can we strengthen our plan
	  ○ Theme
	  ▪ Stacy – emphasis on information about data migration. There are a lot of questions out in the field. We direct people to the website.

- Victor – the data will be migrating from HealthCare.gov with people who have active enrollments, this will include NPN (national producer number)
- Om – will the data also include immigration status documentation?
- Jason from GetInsured – if they have been determined lawfully present in 2026 by the Department of Homeland Security, we will get that information. Due to HR1, we will need to go through the reverification process in the future. As an agent you will be getting notifications to help with data matching issues.

▪ Om – it would be great to have an agent portal so we can access client's information. I am an agent who assists people who speak English as a second language
- Chiqui – yes, there will be different portals for both assisters and agents. Jeff will start agent training mid-July which includes the agent portal.
- Amy – If you want a preview of the agent portal, you can watch it on the January Listening Session.

▪ Kathleen – what about interpretation services
- Amy – we will have native Spanish speakers and access to interpretation services in over 200 languages along with Google translate.

▪ Matthew – would like to see an emphasis on social determinants of health and educate agents and assisters on how to best support underserved communities.
▪ Stacy – a dedicated assister line or a point of contact
- Chiqui – we have purchased a dedicated line, and we do have our liaisons on the program team who will continue to be points of contact.

○ Training timeline
▪ Matthew – when will the platform be finalized? It is important to have a final version, so training isn't constantly being updated.
- Jason – the core product will be done in June with user acceptance testing to follow. Updates will be made on a quarterly basis, and we are constantly looking at ways to improve the system with new enhancements and features. We will share documentation well ahead of any upcoming releases.

▪ Stacy – will the on-demand training be available after the conclusion of the training season on 10/31?
- Amy – yes there will be a library available.

▪ Om – will the training certify us to write business or do we go to the Marketplace?
- Chiqui – whatever you have done with HealthCare.gov you will now do with us.

○ Communication channels
▪ Stacy – we at Moda do a producer roadshow for small group and individual markets towards the end of August. We would love to include some information about available Marketplace training, so we are not fielding questions and we are supporting you.

        - Amy – this is an amazing idea
        - Chiqui – we would love to take you up on the offer. I will have Katie and Anthony work with the carriers to reach out to the carrier reps.
        - Matthew – as an agent we appreciate standalone communication reminders from the carriers, and it builds a sense of partnership.
    - Ron – will the consent form still be required, if so, will it be streamlined?
        - Amy – I believe the form will still be required, we are still evaluating forms and seeing how we can update them.
    - Ron – will there be a special enrollment period (SEP) or contingency plan for people who are confused about the change?
        - Chiqui – the open enrollment is dictated by the federal government and is 11/1 through 12/31. This change is not eligible for an SEP.
    - Ron – what about 1095s for 2026?
        - Chiqui – since they enrolled through HealthCare.gov for 2026 they will go through HealthCare.gov to get their 1095 for that plan year.
- Help with confidence
    - Matthew – the timeline is aggressive and some in the agent and assister community have some PTSD from Cover Oregon. Having the finished product mid-year is huge and is inspiring confidence.
    - Om – what would be best is simplicity and having it be straightforward. Not having to answer so many questions or as an agent having to spend a lot of time explaining.
        - Chiqui – noted, we are trying to find the balance between that and HR1 requirements that start 1/1/2027. We will offer opportunities for feedback.
        - Amy – we have put a lot of effort into plain language
        - Om – in a simple case, an enrollment should only take a half hour
        - Jason – in other states, they have seen from account creating to completing the enrollment within a half hour.
    - Kathleen – a simple Explanation of Benefits would also help so people can understand what they have purchased.
    - Paul – the good thing is that we will have flexibility with our own platform going forward.
        - Chiqui – We are excited to take over the agent training; we have been training the community partners for the last eight years. The transition won't be seamless, but we will be available if you need to contact us.
    - Ron – with the data migration is there a timeline?
        - Jason – This is our tenth state, so we do have some confidence in our process. In May, we will get a full data set from HealthCare.gov and take it through the entire data migration and auto renewal process. We will identify any issues. We will get our next set of data in July and August and will continue to go through the

process with the goal of getting 99% of the folks successfully migrated. What brokers or agents should expect is to get an invitation prior to go live with a unique link to access your agent portal to view your book of business. You will have a dedicated phone line for brokers and assistants if you need any support.
    - Stacy – has seen the process with Your Health Idaho and has been able to assure brokers that it went well.
- Stacy – are we able to change the dates of the open enrollment?
    - Chiqui –federal guidelines state that it starts no later than 11/1 and ends no later than 12/31. We choose to maximize our time. Idaho chooses to end their open enrollment sooner.
    - Kathleen – what about if they retire?
    - Chiqui – if they lose their minimum essential coverage, that would qualify them for an SEP.
-

Public comment	• No public comments given
Federal developments & state impacts 1:05:01	Presenters: Victor Garcia, Marketplace Operations Advisor and Program Liaison and Katie Button, Marketplace Plan Management and Policy Advisor (See pages 10-11 of the handout packet for a copy of the slides.) • Matthew wanted to verify that the income verification variance historically has been 20 percent and if that will be continued. Katie believes that it will continue to be the same. • Charlie was curious if at the state level there was anything we could do to the bronze plan actuarial variance (AV) calculator to help people not enroll in objectionable plans. Katie indicated that our carriers have been good at squeezing every bit of AV out of the bronze plans. Plans will be filing in June so we will be able to see what will be offered for the next plan year. • Charlie wondered if there was a way to opt in to auto enrollment when they initially enroll in a plan. Katie stated that we already do that and we are still awaiting final guidance on what the auto enrollment process will be going forward. • Om questioned about catastrophic plans and if we could have one for people over 200% of the Federal Poverty Limit (FPL). Katie did some research in the five major cities across the country and only one had bronze plans that were more expensive. Om would like to see more plans that are lower deductible and lower out of pocket. • Clare added that OHA's approach is to seek policy flexibility in regard to implementing HR1 changes to keep people covered.
Oregon Health Policy Board Updates 1:19:46	Presenter: Bill Kramer, OHPB (Oregon Health Policy Board) Member & HIMAC Liaison • OHPB has identified two major priorities: affordability and primary care. ○ Affordability initiative launched last year were charged with developing short- and long-term policy recommendations. Also, they will be looking at protecting consumers from the high cost of healthcare and addressing the root causes.

        - An Affordability Committee has been formed, and they will be presenting to the OHPB this summer on which recommendations should go forward.
    - Primary Care Strategy Committee launched this year, and they are looking at the crisis facing workforce shortages and stresses on providers. The committee consists of 18 members including representatives of primary care provider groups, patient groups, CCOs and two members of the state legislature. The first meeting is April 28.
- OHPB looks forward to its continued partnership with the Marketplace and supporting the development of our SBM.
- Stacy is excited about the work that OHPB is doing and is concerned about the decline in enrollment. She is looking forward to more updates on affordability. Bill shared that there is a lot of good information on the Affordability Committee website including minutes and would be a great place to keep up to date: oregon.gov/oha/HPA/HP/Pages/affordability-committee.aspx
- Kathleen wanted to address a primary care issue about limited appointment time availability. If people have more than three concerns and they have to wait to come back and pay another copay, they could risk being admitted to the hospital. Bill agrees that this is a systemic problem and is an issue that won't be fixed overnight.
- Om wondered if alternative providers, such as naturopaths or a PA could be a solution. Many insurers do not consider them a PCP (primary care physician). Bill thinks it is worth looking at the licensing requirements to see if they can be expanded.

Providence Health Plan update
1:33:42

Presenter: Chiqui Flowers, Marketplace Director

- On March 19, Providence sent out a press release that they are exploring their options on selling their health plans. It will not have any impact on the 2026 Marketplace coverage. It is not determined what will happen for 2027 coverage. We will keep you updated as we get information.
- Stacy wanted to know how we would find out. Katie informed us that we usually have two ways: request for applications and rate filings. Generally, the carriers give us heads up, but sometimes things are behind the scenes.
- Matthew wondered if anyone has expressed any interest. Chiqui hasn't heard anything yet.
- Charlie wanted to know if the sale would have to go through the Healthcare Market Oversight program. Clare stated that it depends on the transaction.

Marketplace Open Enrollment & SPM Launch Communications: Workshop
1:39:27

Presenter: Amy Coven, Marketplace Communications and Public Engagement Analyst
(See pages 12-13 of the handout packet for a copy of the slides.)

- Stacy wanted clarification on the timeline as it seemed to omit September. Amy stated that May, July, and October are key dates, but activities are happening throughout.
- Kathleen wondered if in addition to social media, other types of media -- such as TB and radio -- were being used. Amy confirmed that we do have wonderful contacts with all types of media and will be using them.
- Om asked if she would be able to add information about Explore Health into her quarterly newsletter. Amy requested holding off until we officially announce the name to our partners.

- Om suggested that we make sure that things are in simple language. Some of her clients have immigration attorneys that are telling them not to get insurance and then they go to the emergency room and have a big bill. Would like to see something explaining to them in simple language why insurance is important.
- Alena added that maybe having a launch party to spread the word at local libraries would be a good and free location.

Marketplace Strategic Planning: workshop
2:01:26

Presenters: David Simnitt, Principal, DS Consulting; Katie Button, Marketplace Policy and Plan Management Advisor
(See pages 14-15 of the handout packet for a copy of the slides.)

- Affordability
    - AV calculator
        - Level funded pulls the healthy risk out of the individual and small group markets and that's how they achieve a lower premium. It's good for the people who have that option but creates challenges for the people who remain in the regulated market.
        - Fixed copay on labs in the standard plans. Equity issue as some communities of color needs more labs due to health issues that tend to be prevalent in those communities. It would be okay to increase deductible some to accommodate the lab copay.
        - Support affordability by making people aware of their options and getting them covered. The more people we cover, the more affordable coverage is. Having an SBM and being able to control the messaging and experience will help get more people covered.
    - ICHRAs
        - The 50-99 employee groups are really interested in ICHRAs. Worry about the risk to the individual market. Moving higher risks and higher claims folks into the market. Moves the bad risk from the employer group into the individual market. If the market is growing, the market can probably handle it.
        - If we can get more employers in general to do it, rather than those looking to escape high premiums due to bad risk. We could possibly look at MLR (medical loss ratio) by product segment to determine how risk is moving. Looking at rate trends.
        - The employers looking at ICHRAs (Individual Coverage Health Reimbursement Arrangement) are working with an agent, so anything we can do to scale up the agent community will help support that.
        - It is easier to put small groups in small group plans than sending 1-2 employees to HealthCare.gov.
    - Other ideas
        - Driving people to lower cost sites and reducing actual prices of healthcare.
        - Looking at profit margins vs what's being received by the consumer. Lots of money in the healthcare system, but we don't know where it's all going.
    - What does success look like?

        - The size of the pool. The market is eroding over time. We should have clear retention goals, and then also growth goals. Figuring out why people are leaving will allow us to refine strategies. Trying to track movement of folks better across different markets, including self-funded large group.
        - Utilization rates - are people using their coverage and accessing high-value services. Possibly use APAC (All Payer All Claims) database?
        - Having very simple instructions on how to access care, especially for populations that have chronic diseases.
        - Measuring affordability from various participants' perspectives will help. Many things will take more than one year to implement.
        - Tell people to use their plans. Having information that's more scenario-based would help people understand what to expect. Tell people how to use virtual options that are free or at a lower cost. Get the carriers to send us their tips and tricks for how to best use their plans. Model information from the "Welcome to Medicare" booklet. Different information for people who are new vs re-enrollments.
        - $10 gift card would motivate people to access care
        - "Climb the Mountain", start with getting a PCP, then different levels of care until you are on a path to wellness.
- Enhance Consumer Experience
    - The Oregon tools (Window Shopping and our future SBM) have been much better than HC.gov
    - Anonymous browser that flows more smoothly into an application (saves some information and inputs it into the application).
    - Identifying pain points in the application process to reach out to folks to help and also to identify future updates to make the application process easier to complete.
    - What does success look like?
        - Focus groups? UAT (user acceptance testing) with people who aren't state employees. Possibly a survey after someone enrolls. A simple thumbs up/thumbs down and then ask people if we can contact them to learn more.
        - Time on page for each section - how much time are people spending getting information complete? Are there outliers? Tracking overall time to completion and how many visits to complete application and enrollment? If people are having to come back multiple times, they may need adjustments. Maybe the system could tell people up front about how long it will take? Provide information on what people will need. A checklist.
- Improve Integration and Retention
    - In the agent portal, agents can see if their folks have been processed and determined eligible for Medicaid after ONE has sent back confirmation to the SBM.
    - More notices from OHP/OHP Bridge would be helpful when coverage is ending, or possibly different notices. Maybe Marketplace call center could make outbound calls or send emails to folks who are coming to the Marketplace from OHP (our folks we get on the weekly reports).

	○ For Marketplace enrollees, as we're getting close to OE, possibly a countdown that will help consumers know when the end of the plan year is coming. ○ Integration into the Find Help tool for folks to be connected to an agent or CP when their application goes to ONE. Sometimes applications get stuck in ONE processing, and it would be great to get folks connected with someone who can help them track that and resolve it. ○ Goal should be 100% success rate in transitioning folks between OHP and Marketplace. • Upgrade Partner Tools ○ SLAs for partners so they know what's reasonable and when they should be expecting follow up or resolution. It would also be something we could track. ○ Can we have a URL for agents to use so folks can connect them more easily. • Expand Equity and Access ○ Sometimes translations are not good. Google translate doesn't always capture syntax appropriately. Having native speakers review documents is helpful. Try to find people who are also translators for medical terminology. ○ Meet the Marketplace so people can get to know the staff more Let them know we live here with them and are looking forward to helping them.
Public comment, wrap up & closing 2:46:57	• Rick Blackwell from PacificSource advised having patience for roll out of the platform to restore public trust. Urge broader conversation about strategic priorities to bring some more voices in when completing the strategic plan. • Next meeting is the Assessment Rate meeting on June 25, 2026. Our next regularly scheduled meeting is July 16, 2026. It is currently virtual but will likely be changed to hybrid.

*These minutes include timestamps from the meeting recording in an hour: minutes: seconds format. Meeting materials and recording are found on the Oregon Health Insurance Marketplace Advisory Committee website under 2026 Meetings, February 19.

MEMORANDUM

June 26, 2026

To: Chiqui Flowers, Director of the Oregon Health Insurance Marketplace, Health Policy and Analytics (HPA) Division, Oregon Health Authority
Dr. Sejal Hathi, Director, Oregon Health Authority
Kris Kautz, Deputy Director for Administration, Oregon Health Authority
Rochelle Layton, Chief Financial Officer, Oregon Health Authority
Clare Pierce-Wrobel, HPA Director, Oregon Health Authority
Liz Mill, HPA Technology and Budget Manager, Oregon Health Authority

From: Caleb Lavan, Senior Manager, CBIZ Optumas

Subject: Oregon Health Insurance Marketplace Report – CY 2027 Administrative Charges
Health Insurance Marketplace Advisory Committee Material

Issue

The Oregon Health Insurance Marketplace (OHIM) is required to review its assessment rates on an annual basis. OHIM needs to determine assessment rates for Marketplace individual medical plans and for stand-alone dental plans for CY 2026. The current assessment rates are:

- $6.85 per member per month (PMPM) for individual medical health plans
- $0.45 PMPM for stand-alone dental plans

ORS 741.105 requires that proposed rates be discussed with the Health Insurance Marketplace Advisory Committee. OAR 945-030-0020 requires a report on the proposed assessment, and a public hearing.

This memo provides information on OHIM expenditures and possible Marketplace enrollment patterns. These generate estimates of the assessment rates that would cover projected operational expenditures for the program. The memo also discusses the costs of the federal technology and the total combined assessment as a percentage of the average premium.

Summary

- We use expenditure assumptions based on estimated monthly expenditures provided by OHIM and the Health Policy and Analytics Business Operations office.
- Preliminary data indicates CY 2027 will have a lower level of enrollment than CY 2026, due to impacts from the end of the Enhanced Premium Tax Credits (EPTC) and continuing affordability issues, the Oregon Health Plan (OHP) Bridge, and insurer withdrawal from the individual market.
- Expenditures are expected to increase with the transition to a state-based marketplace. Payments from insurers will transition away from the federally facilitated marketplace to the state.
- Our analysis suggests that the PMPM rates need to be increased to $35.60 for individual medical health plans and $1.70 for stand-alone dental plans in CY 2026 to cover the operating costs of OHIM.

Assessment rate history

The following table shows the recent history of the Marketplace assessment rates. The rates remained at $5.50 through CY2025, and increased to $6.85 in CY 2026

Marketplace Assessment Rates

	CY 2017 - CY 2019	CY 2020 - CY 2025	CY 2026	CY 2027
Medical PMPM	$6.00	$5.50	$6.85	TBD
Dental PMPM	$0.57	$0.36	$0.45	TBD

The dental assessment rate was set so the ratio of the dental rate to the medical rate equaled the ratio of the average dental premium to the average medical premium. Average dental premiums have not risen as fast as medical premiums, so the dental rate remained unchanged through CY 2025. In CY 2026, it was raised to $0.45.

Current expenditure projections

The following table shows our current expenditure forecast. The figures are based on historical expenditures and expenditure estimates for the next biennium broken down by calendar year provided by staff.

Marketplace Expenditures, Historical and Projected

CY 2022-2025 actuals and CY 2026-2027 forecast

	Marketplace Expenditures	Shared Services / SAEC	Total Expenditures
CY 2022	$6,071,063	$320,887	$6,391,950
CY 2023	$6,563,747	$936,474	$7,500,221
CY 2024	$6,958,386	$1,074,828	$8,033,214
CY 2025	$7,319,331	$1,360,893	$8,680,223
CY 2026	$14,889,794	$1,666,537	$16,556,331
CY 2027 *	$33,924,962	$5,309,994	$39,234,956

SAEC - OHA Shared Assesment and Enterprise-wide Costs

*Expenditure increases in CY 2027 are a result of the transition to a state-based marketplace (SBM).

The table shows actual expenditures for CY 2022 - CY 2025.

Actual expenditures were available through 2025 and projected expenditures from 2026 forward were taken from the expenditure estimates provided by staff.

Marketplace medical plan enrollment forecast

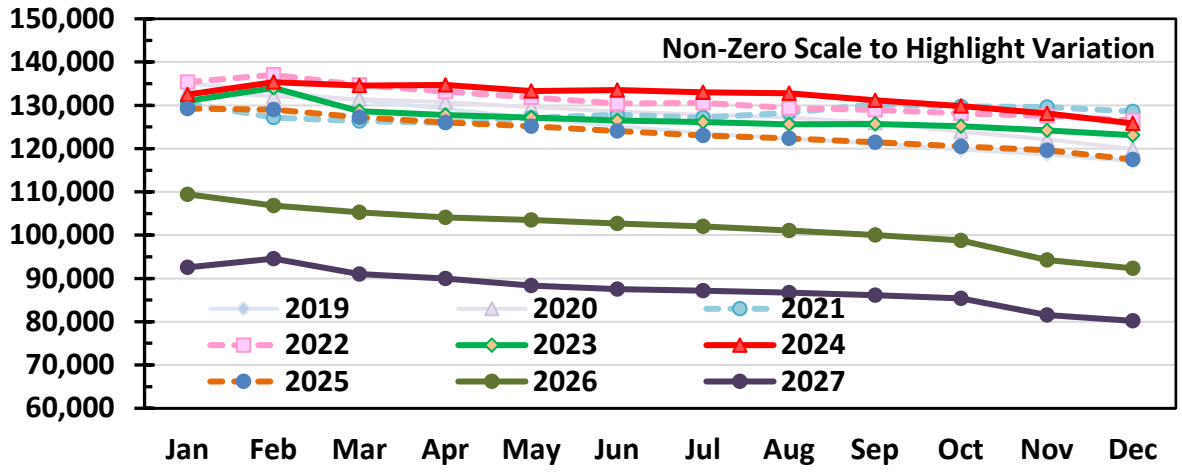
The assessment rate needed to fund the Marketplace's operations is dependent on the forecasted effectuated medical plan enrollment ("medical enrollment").

The basic approach to forecasting the medical enrollment was to create a baseline forecast using the recent history and then adjust that to account for anticipated changes that may impact the medical enrollment.

The first step is to develop the recent history. There can be significant volatility in carriers' reported enrollment. Carriers are allowed to revise enrollment for up to 18 months. Some years the variation is larger than other years. Careful review of trends of missing data from past years showed that the volatility in enrollment numbers was most likely to be present in the preliminary enrollment numbers at the beginning of the year during open enrollment and right after. In years past, this report was completed using only the preliminary enrollment data reported for January and February. As a result, the volatility in the beginning of the year needed to be accounted for in our forecast. This year, the report was contracted for later in the year, allowing the use of enrollment numbers through May of 2026. This allowed time for the January and February enrollment numbers to stabilize. The annual May data does not generally show any significant changes or volatility over time and so we were able to use them without adjustment.

We observed 103,538 enrollees for May 2026. With that value and the stable enrollment numbers from January to April of 2026 as the starting point for the CY 2026, we then applied a seasonal exponential smoothing model to the period from January 2022 to May 2026. This captures the recent trend and seasonal pattern of enrollment. The chart below shows the last several years of medical enrollment. Note the distinct seasonal pattern with the highest enrollment in January and February, during and immediately after open enrollment and then enrollment gradually declining over the year. You will note the 2026 and 2027 numbers are distinctly lower. The drop from 2025 to 2026 was driven in large part by the end of the Enhanced Premium Tax Credit (EPTC), but also the OHP bridge plan. The impact of the end of the EPTC has already occurred, but the transfers to the OHP are ongoing. We will discuss the specifics of the changes next.

Enrollment Model: Effectuated Medical Plan Enrollment, CY 2026 and CY 2027 Forecasted, CY 2026 Actuals, based on May 2026 enrollment reports



Discussion of factors impacting the medical plan enrollment forecast

There are a number of factors that may impact the medical plan enrollment in CY 2027: absence of enhanced premium tax credits, transfers of enrollees to OHP Bridge, and withdrawal of insurers from the individual market. Other factors that could impact medical enrollment but were not directly accounted for in the model include changes to the open enrollment period, end of automatic reenrollment, end of provisional eligibility for advanced premium tax credits, changes in federal legislation and guidance, and the state of the economy. We will discuss the first two factors, which was modeled in the forecast and then we will address the other risks that were not modeled in the forecast.

End of Enhanced Premium Tax Credits ("No EPTC")

Enhanced premium tax credits were implemented during the pandemic and extended through 2025 to provide greater access to affordable health insurance. These tax credits were used to reduce the insurance premiums that members of Marketplace pay based on income. The average recipient received $800 in additional subsidies according to the US Department of Health and Human Services. This provision of the law sunset at the end of 2025. While most of the impact of the expiration of the EPTC was seen in CY 2026, there may be an additional decrease in Marketplace medical plan enrollments seen in CY 2027, as some members continue to be priced out of the Marketplace due to an increase in premiums.

OHP Bridge

OHP Bridge covers adults with income between 138 and 200 percent of the federal poverty level, providing medical and dental healthcare to members with no premiums, co-payments, or deductibles. Prior to the implementation of the OHP Bridge, the Marketplace covered people with eligibility from 138% FPL and up. A decrease in Marketplace medical plan enrollment is expected as eligible individuals shift their medical plan to coverage under the OHP Bridge.

The impact of OHP Bridge was expected to decrease enrollment over a significant period of time. Approximately 3,150 members are expected to move from the Marketplace to OHP Bridge from June 2026 to December 2026 and an additional 2,850 from January 2027 to July 2027, for a total of 6,000 members over the 12-month timespan

The impact of OHP Bridge was applied to the baseline exponential smoothing forecast model resulting in an estimated average medical enrollment for CY 2027 of 93,182. See the graph below.

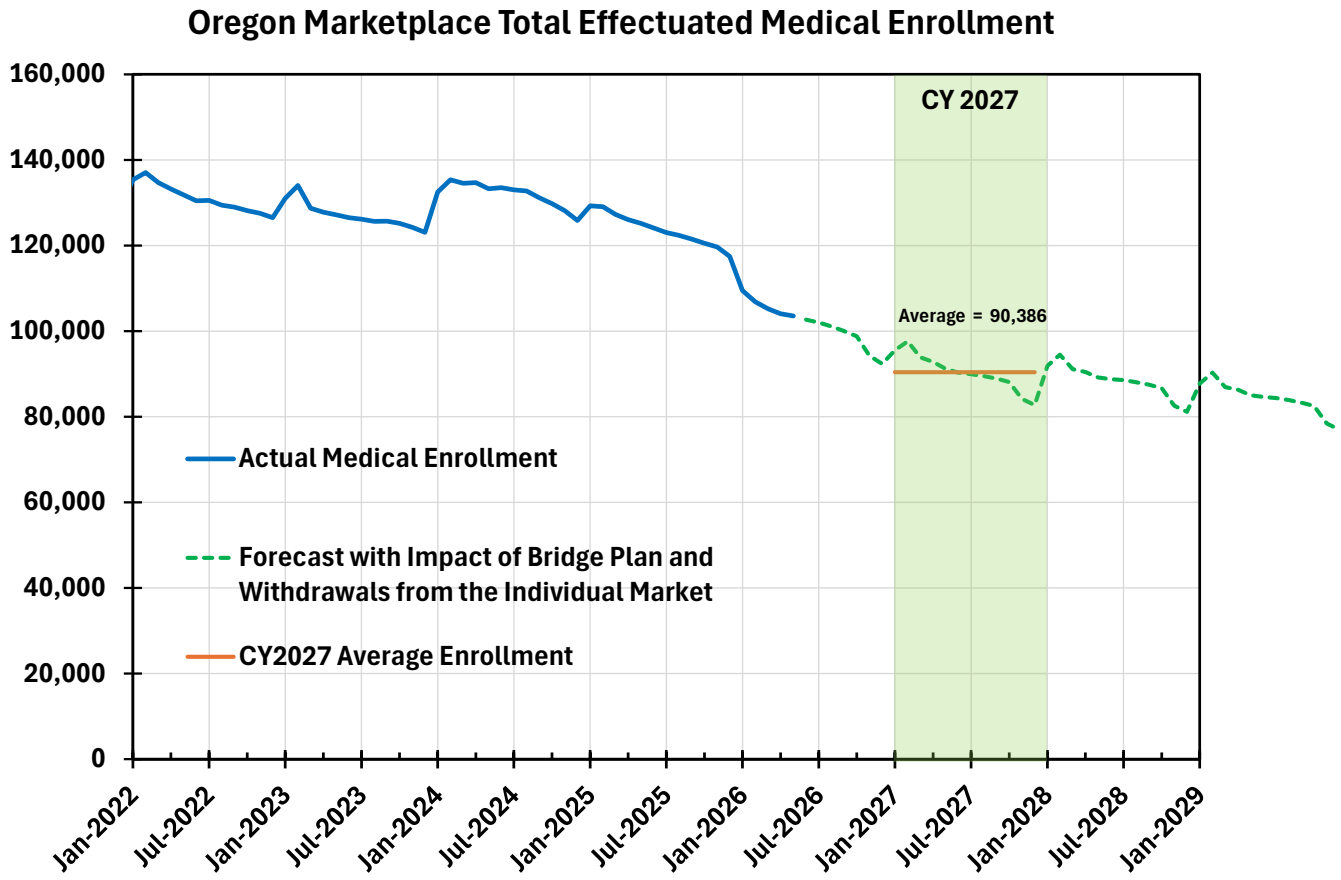
Withdrawal of Insurers from the Individual Market

Two insurers are planning to withdrawal from the marketplace in 2027, Providence and PacificSource. They collectively serve approximately 34% of market. There is some older research that when a participants insurer exits the Healthcare marketplace, it increases the likelihood of the participant disenrolling by a range of 7% to 13%.[1] In this case, 34% will see their insurer exit, corresponding to a range of 2.4% to 4.4% for the total decrease.

[1] Crespin and DeLaire, "As Insurers Exit Affordable Care Act, So Do Consumers", Health Affairs, 38, (2019)

To confirm this estimate, we examined the average disenrollment in 2026 between state-based marketplaces that had no insurer withdrawals and those that did. We used the OEP State Level public use files and examined the disenrollment numbers by state. We also used a list of insurers that had withdrawn by state[2]. Thirteen states with a state-based marketplace had no insurer withdrawals in 2026 and 8 states did. The weighted average disenrollment rate was 19% in states with an insurer withdrawal and 16% in states without a withdrawal, for a difference of 3%. This is consistent with estimate in the previously mentioned paper.

We decreased the enrollment after accounting for the reduction due to the Bridge plan by an additional 3% for our final forecast.



Other Factors Not Included in the Forecast

The open enrollment period causes a significant increase in the number of new enrollees. An increase or decrease to the length of the open enrollment period could increase or decrease the enrollment. In compliance with the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) Marketplace Integrity and Affordability Rule

[2] https://www.healthinsurance.org/faqs/my-health-insurance-company-is-leaving-my-market-what-can-i-do/, Accessed May 21, 2026.

released in 2025, Oregon will be reducing its open enrollment period for plan year 2027 by two weeks and ending it on December 31, 2026.

Federal provisions that proposes additional restrictions on premium tax credits may price individuals out of the Marketplace. Federal legislation such as H.R. 1 implements additional work requirements that may result in individuals losing Medicaid eligibility and enrolling in the Marketplace.

The last factor to consider is the economy and health insurance availability. Fundamentally, the number of people eligible for the Marketplace is driven by how many are in the eligibility bracket (200% FPL and up) and who also lack health insurance. The current job market has been surprisingly steady, and unemployment is relatively low. If that continues, it may lift more people out of Medicaid and onto the Marketplace. It may also lift people into jobs with employer sponsored health insurance and out of the Marketplace. Economic downtown may result in the opposite effects, causing more people to become eligible for Medicaid income requirements, while simultaneously causing people to lose employer sponsored health insurance. The overall impact may be mixed. However, the overall uncertainty and potential volatility is large.

Individual medical plan assessment rates

The following table shows the revenue generated by combinations of individual medical plan enrollment and assessment rates. Under the enrollment model described above, the forecast of the average monthly enrollment for CY 2025 would be 90,386 members. An assessment rate of $35.60 PMPM would generate $38.6 million in revenue. With the same enrollment, a $30.00 PMPM would generate $32.5million. If the average enrollment were 10,000 a month lower than forecast, the $35.60 PMPM would generate $34.3 million; if the enrollment were 10,000 a month higher, the $35.60 PMPM would generate $42.9 million.

CY 2027 Revenue ($millions) by Assessment Rates

Medical Enrollment Forecast	PMPM assessment rates ($dollars)					Equlibrium Rates ($dollars)
	$25.00	$30.00	$35.60	$40.00	$45.00	
Forecast + 15,000	$31.6 mil	$37.9 mil	$45.0 mil	$50.6 mil	$56.9 mil	$30.53
Forecast + 10,000	$30.1 mil	$36.1 mil	$42.9 mil	$48.2 mil	$54.2 mil	$32.05
Forecast + 5,000	$28.6 mil	$34.3 mil	$40.7 mil	$45.8 mil	$51.5 mil	$33.73
Forecast = 90,386	$27.1 mil	$32.5 mil	$38.6 mil	$43.4 mil	$48.8 mil	$35.59
Forecast - 5,000	$25.6 mil	$30.7 mil	$36.5 mil	$41.0 mil	$46.1 mil	$37.68
Forecast - 10,000	$24.1 mil	$28.9 mil	$34.3 mil	$38.6 mil	$43.4 mil	$40.02
Forecast - 15,000	$22.6 mil	$27.1 mil	$32.2 mil	$36.2 mil	$40.7 mil	$42.68

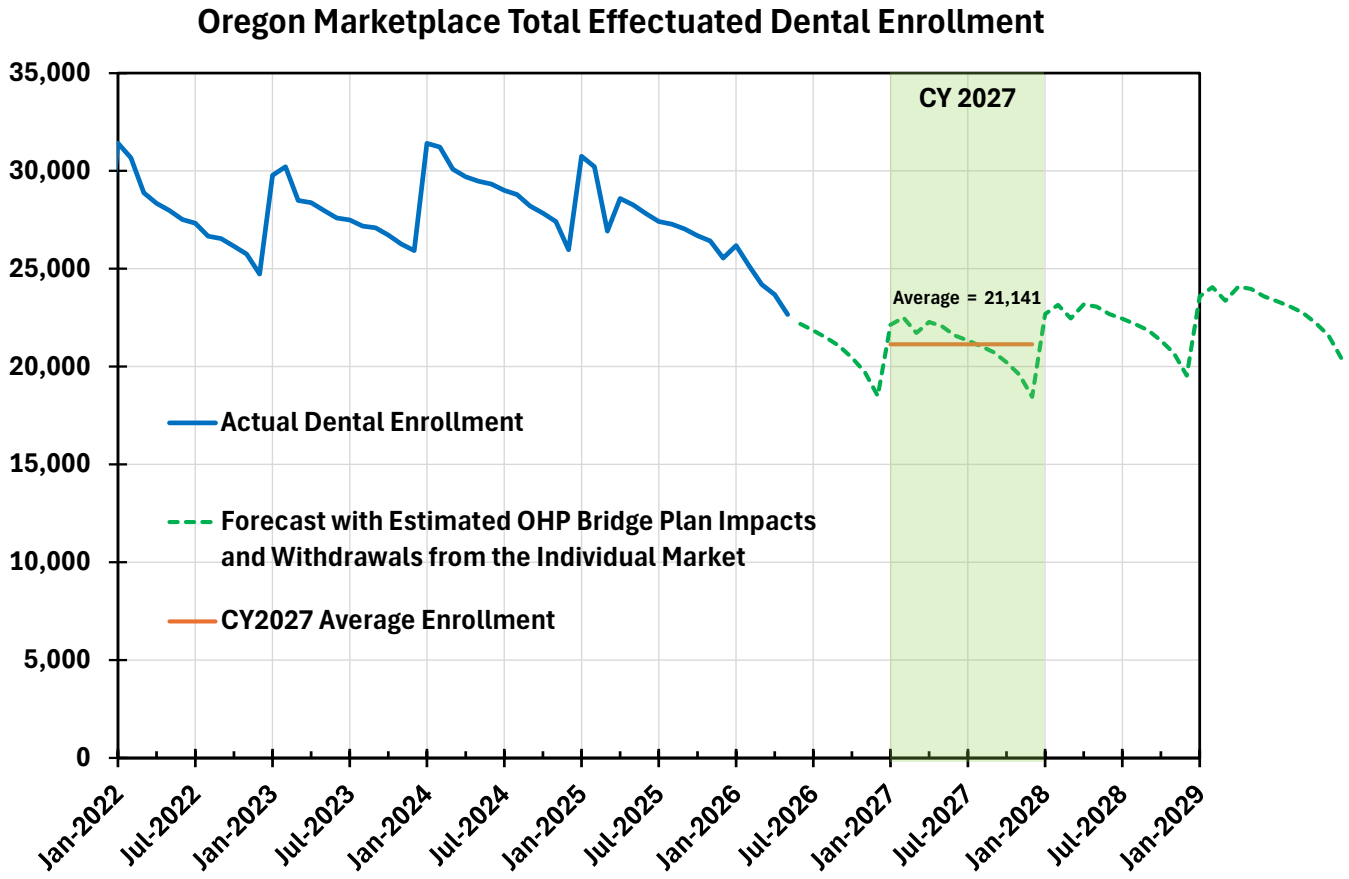
In our financial modeling, we define the "equilibrium rate" as the assessment rate needed to cover one year of expenditures. Using the expenditures described previously, CY 2027 total expenditures are forecasted to be $39,234,956. The dental plan assessment is estimated to raise $431,275 and investment income will generate about $196,980, for a total of $628,255, so the medical plan assessment will need to generate about $ 38.6 million.

The table shows the equilibrium rates for various enrollment forecasts in the right column. If the enrollment forecast is correct, the equilibrium rate for the continuing service level Governor's

Budget expenditures is $35.59 PMPM. If monthly enrollment were 5,000 higher, the equilibrium rate would be $33.73 PMPM.

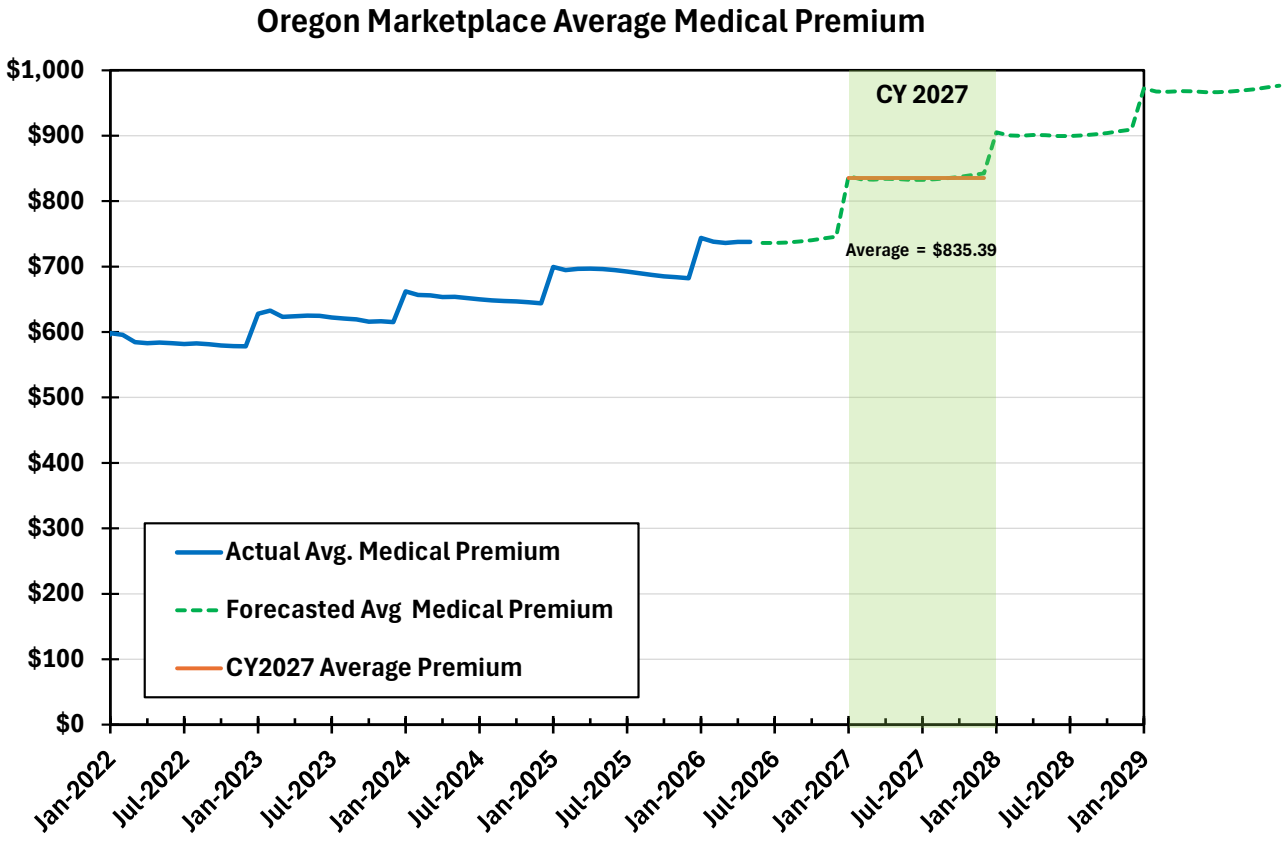
Stand-alone dental plan enrollment and premiums forecast

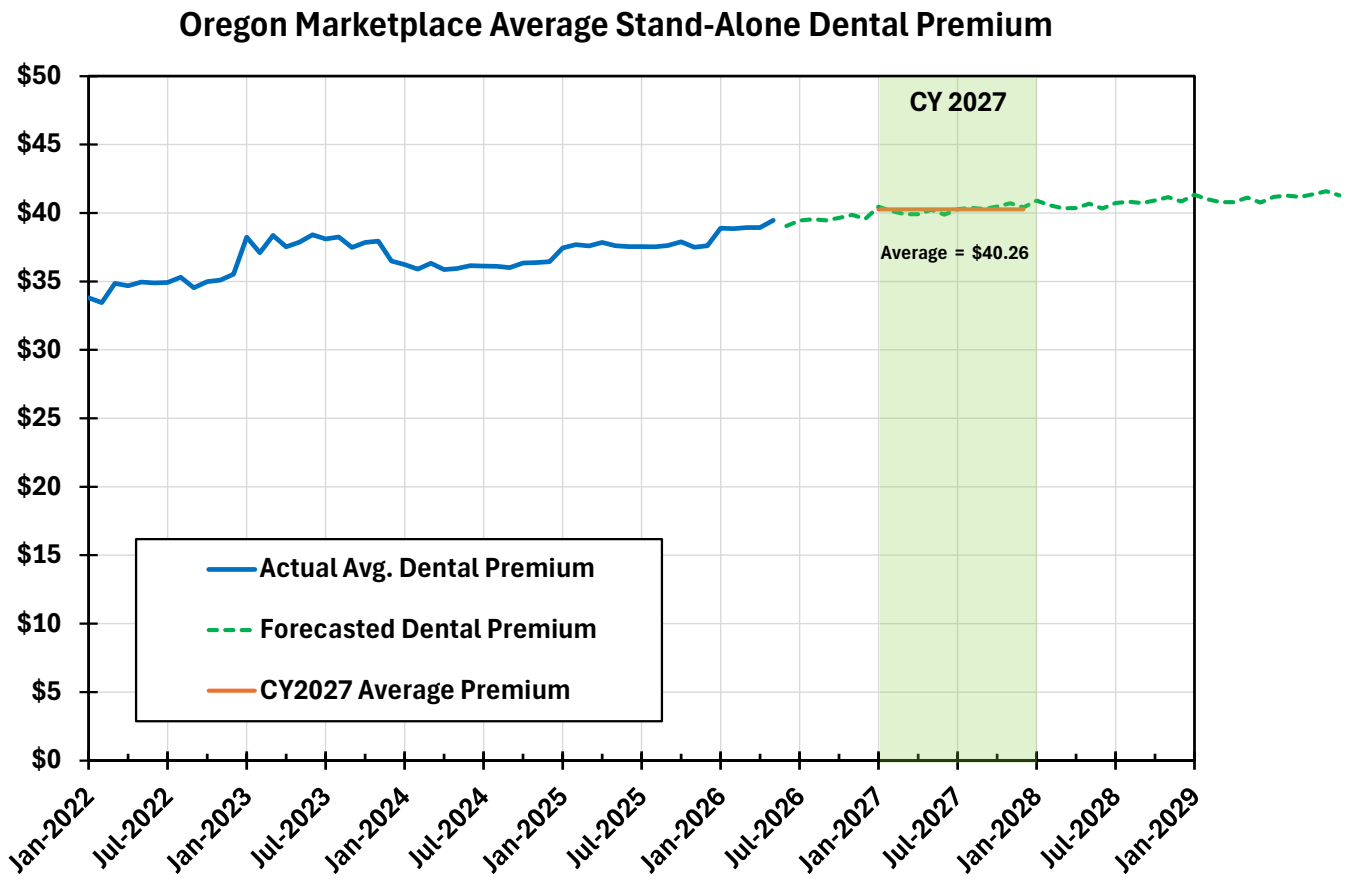
Dental plan enrollment has moved up and down over the last few years. Like the medical enrollment forecast, we first forecast a baseline forecast using an exponential smoothing model. Our forecast for stand-alone dental enrollment decreases the enrollment estimates by the same relative amount as the medical enrollment estimates. There is only one insurer withdrawing from the stand-alone dental market, PacificSource and they have a smaller footprint, we estimate the impact to be a 1% decrease to projected enrollment and that is built into the Dental enrollment forecast.



We also need to forecast medical and dental premiums to ensure that the assessments will not exceed certain limits. Medical premiums have shown significant increases in the last few years. We use the historical value for the average premium by month from January 2022 to May 2026. The discussed premium increases for 2027 are generally higher due to the decrease of enrollment under the end of the Enhanced Premium Tax Credits in 2026. In addition, the 2 insurers withdrawing from the individual market will likely lead to additional increases. We specifically included a 4% increase to premiums for 2027 above the normal forecasted increases to account for these factors. The forecasted average premium in CY 2027 is $835.39. The medical and stand-alone dental premium forecasts are both shown on the next page.

Stand-alone dental premiums have grown slower than medical premiums, but they have increased. We forecast that current trend will continue into CY 2027 and include a 1% increase above the normal forecasted increase. The average premium for a stand-alone dental plan is forecasted to be $40.26.





Enrollment forecast summary

The following table provides a summary by calendar year using the current assessment rates, the proposed enrollment forecast, and the state provided expenditure estimates. The table also includes the forecast average premiums for medical and stand-alone dental policies. CY 2027 and the medical assessment are highlighted with dashed lines.

Medical Plans Summary, with Assessment Rate Assumptions

	2021	2022	2023	2024	2025	2026	2027
Average enrollment	128,217	131,135	127,100	132,045	123,789	101,689	90,386
% change	0.4%	2.3%	-3.1%	3.9%	-6.3%	-17.9%	-11.1%
Total premiums ($ millions)	$886.3	$919.3	$949.1	$1,032.1	$1,027.3	$901.4	$906.1
Avg premium	$576.02	$584.19	$622.29	$651.33	$691.58	$738.71	$835.39
% change	7.8%	1.4%	6.5%	4.7%	6.2%	6.8%	13.1%
Assessment rate	$5.50	$5.50	$5.50	$5.50	$5.50	$6.85	$35.60*
Assessments ($ millions)	$8.5	$8.7	$8.4	$8.7	$8.2	$8.4	$38.6
Rate as % of avg premium	1.0%	0.9%	0.9%	0.8%	0.8%	0.9%	4.3%
Federal tech. charges ($ millions)	$15.5	$20.7	$21.4	$18.6	$12.3	$18.0	$0.0
Fed. as % of avg premium	1.75%	2.25%	2.25%	1.80%	1.20%	2.00%	0.00%

Dental Plans Summary

	2021	2022	2023	2024	2025	2026	2027
Average enrollment	26,367	27,664	27,759	29,039	27,745	22,260	21,141
% change	12.7%	4.9%	0.3%	4.6%	-4.5%	-19.8%	-5.0%
Total premiums ($ millions)	$10.6	$11.5	$12.6	$12.6	$12.5	$10.6	$10.1
Avg premium	$33.42	$34.75	$37.80	$36.15	$37.62	$39.51	$39.86
% change	-7.9%	4.0%	8.8%	-4.4%	4.1%	5.0%	0.9%
Assessment rate	$0.36	$0.36	$0.36	$0.36	$0.36	$0.45	$1.70*
Assessments ($ millions)	$0.114	$0.120	$0.120	$0.125	$0.120	$0.120	$0.431
Rate as % of avg premium	1.1%	1.0%	1.0%	1.0%	1.0%	1.1%	4.3%
Federal tech. charges ($ millions)	$0.185	$0.260	$0.283	$0.227	$0.150	$0.211	$0.000
Fed. as % of avg premium	1.75%	2.25%	2.25%	1.80%	1.20%	2.00%	0.00%

Medical and Dental Combined

	2021	2022	2023	2024	2025	2026	2027
Total premiums ($ millions)	$896.8	$930.8	$961.7	$1,044.7	$1,039.8	$912.0	$916.2
Total assessments ($ millions)	$8.58	$8.77	$8.51	$8.84	$8.29	$8.48	$39.04*
Total fed. Charges ($ millions)	$15.69	$20.94	$21.64	$18.80	$12.48	$18.24	$0.00
Assessment and fed. charges ($ millions)	$24.27	$29.72	$30.15	$27.64	$20.77	$26.72	$39.04
Total % of avg premium	2.7%	3.2%	3.1%	2.6%	2.0%	2.9%	4.3%

***Assessment rate increases in CY 2027 account for expenditure increases as a result of the transition to a state-based marketplace (SBM).**

Marketplace financial outcomes

The following table summarizes the forecast financial outcomes with the current assessment rates. The CY 2022 – CY 2025 figures are actual revenue and expenditures.

The CY 2026 – CY 2027 figures show the forecast if the enrollment and expenditure assumptions are correct. The revenue figures reflect the assessment revenue and investment revenue. The fund balance forecast is forecasted to stay level through CY 2027.

Summary of Financial Outcomes, Current Assessment Rates

	Total Expenditures	Total Revenue	Fund Balance
CY 2022	$6,391,950	$8,131,190	$8,240,013
CY 2023	$7,500,221	$9,395,352	$10,135,144
CY 2024	$8,033,214	$9,753,736	$11,855,666
CY 2025	$8,680,223	$8,788,055	$11,963,498
CY 2026	$16,556,331	$8,835,251	$4,242,418
CY 2027 *	$39,234,956	$39,241,178	$4,248,640

*Expenditure increases in CY 2027 are a result of the transition to a state-based marketplace (SBM).

An assessment rate of $35.60 is recommended as the rate that will keep the fund balance constant through CY 2027. This assessment rate accounts for known impacts to revenue brought in by the Marketplace, such as decreases in enrollment due to continued affordability issues due to EPTC expiration and increasing premiums, transitions to OHP Bridge, and the withdrawal of insurers; and known impacts to expenditures, such as the transition to a state-based marketplace. Due to potential unknown impacts to the Marketplace that may result from pending or additional federal action, an assessment rate was identified that will help maintain the fund balance to support operations if enrollment decreases further.

Text of SB 972 Relating to the health insurance exchange; creating new provisions; amending ORS 741.105 and 741.300; repealing ORS 741.107; and declaring an emergency.

SECTION 1. Section 2 of this 2023 Act is added to and made a part of ORS 741.001 to 741.540.

SECTION 2. The Oregon Health Authority shall procure and administer an information technology platform or service, separate from the federal platform, to provide electronic access to the health insurance exchange in this state on and after November 1, 2026.

SECTION 3. ORS 741.105 is amended to read:

741.105. (1) The Oregon Health Authority shall establish, by rule, an administrative charge. The authority shall impose and collect the charge from all insurers participating in the health insurance exchange or offering a health plan certified by the authority and state programs participating in the health insurance exchange. The Health Insurance Exchange Advisory Committee shall advise the authority in establishing the administrative charge. The charge must be in an amount sufficient to cover the costs of grants to navigators, in-person assisters and application counselors certified under ORS 741.002 and to pay the administrative and operational expenses of the authority in carrying out ORS 741.001 to 741.540. The charge shall be paid in a manner and at intervals prescribed by the authority.

(2)(a) Each insurer's charge shall be based on the number of individuals, excluding individuals enrolled in state programs, who are enrolled in health plans:

(A) Offered by the insurer through the exchange; and

(B) Certified by the authority.

(b) The charge to each state program shall be based on the number of individuals enrolled in state programs offered through the exchange.

(3) The charge imposed under this section may not exceed:

(a) Five percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is at or below 175,000;

(b) Four percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is above 175,000 and at or below 300,000; and

(c) Three percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is above 300,000.

(4)[*(a)*] If charges collected under subsection (1) of this section exceed the amounts needed for the administrative and operational expenses of the authority in administering the health insurance Enrolled Senate Bill 972 (SB 972-INTRO) Page 1 exchange, the excess moneys collected may be held and used by the authority to [*offset future net losses.*]:

(a) Establish or administer the state information technology platform or service that provides electronic access to the health insurance exchange;

(b) Subsidize a state premium assistance program; or

(c) Implement other measures to further advance the intent of the Legislative Assembly described in ORS 741.001.

[*(b) The maximum amount of excess moneys that may be held under this subsection is the total costs and expenses described in subsection (1) of this section anticipated by the authority for a six-month period. Any moneys received that exceed the maximum shall be applied by the authority to reduce the charges imposed by this section.*]

(5) Charges shall be based on annual statements and other reports submitted by insurers and state programs as prescribed by the authority.

(6) In addition to charges imposed under subsection (1) of this section, to the extent permitted by federal law the authority may impose a fee on insurers and state programs participating in the exchange to cover the cost of commissions of insurance producers that are certified by the authority [*or by the United States Department of Health and Human Services*] to facilitate the participation of individuals and employers in the exchange.

(7)(a) The authority shall establish and amend the charges and fees under this section in accordance with ORS 183.310 to 183.410.

(b) If the authority intends to increase an administrative charge or fee, the notice of intended action required by ORS 183.335 shall be sent, if the Legislative Assembly is not in session, to the interim committees of the Legislative Assembly related to health, to the Joint Interim Committee on Ways and Means and to each member of the Legislative Assembly. The Director of the Oregon Health Authority shall appear at the next meetings of the interim committees of the Legislative Assembly related to health and the next meetings of the Joint Interim Committee on Ways and Means that occur after the notice of intended action is sent and fully explain the basis and rationale for the proposed increase in the administrative charges or fees.

(c) If the Legislative Assembly is in session, the authority shall give the notice of intended action to the committees of the Legislative Assembly related to health and to the Joint Committee on Ways and Means and shall appear before the committees to fully explain the basis and rationale for the proposed increase in administrative charges or fees.

(8) All charges and fees collected under this section shall be deposited in the Health Insurance Exchange Fund.

SECTION 4. ORS 741.300 is amended to read: 741.300. As used in ORS 741.001 to 741.540:

(1) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(2) "Essential health benefits" has the meaning given that term in ORS 731.097.

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

(4) "Health care service contractor" has the meaning given that term in ORS 750.005.

(5) "Health insurance" has the meaning given that term in ORS 731.162, excluding disability income insurance.

(6) "Health insurance exchange" or "exchange" means [*the division of the Oregon Health Authority that operates*] an American Health Benefit Exchange as described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(7) "Health plan" means a health benefit plan or dental only benefit plan offered by an insurer.

(8) "Insurer" means an insurer as defined in ORS 731.106 that offers health insurance, a health care service contractor, a prepaid managed care health services organization or a coordinated care organization.

(9) "Insurance producer" has the meaning given that term in ORS 731.104.

(10) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025. Enrolled Senate Bill 972 (SB 972-INTRO) Page 2

(11) "State program" means a program providing medical assistance, as defined in ORS 414.025, and any self-insured health benefit plan or health plan offered to employees by the Public Employees' Benefit Board or the Oregon Educators Benefit Board.

(12) "Qualified health plan" means a health benefit plan certified by the authority in accordance with the requirements, standards and criteria adopted by the authority under ORS 741.310.

(13) "Small Business Health Options Program" or "SHOP" means a health insurance exchange for small employers as described in 42 U.S.C. 18031.

SECTION 5. Section 2 of this 2023 Act is amended to read:

Sec. 2. The Oregon Health Authority shall procure and administer an information technology platform or service, separate from the federal platform, to provide electronic access to the health insurance exchange in this state [on and after November 1, 2026].

SECTION 6. ORS 741.107 is repealed.

SECTION 7. (1) The amendments to section 2 of this 2023 Act by section 5 of this 2023 Act and the amendments to ORS 741.105 and 741.300 by sections 3 and 4 of this 2023 Act become operative on November 1, 2026.

(2) The Oregon Health Authority shall take all steps prior to the operative date specified in subsection (1) of this section that are necessary to carry out the amendments to section 2 of this 2023 Act by section 5 of this 2023 Act and the amendments to ORS 741.105 and 741.300 by sections 3 and 4 of this 2023 Act on the operative date specified in subsection (1) of this section.

SECTION 8. This 2023 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2023 Act takes effect on its passage.

Portions of OAR 945-030-0020 Establishment of Administrative Charge Paid by Insurers

945-030-0020 Establishment of Administrative Charge Paid by Insurers

(1) After consulting with the advisory committee … the Marketplace will annually provide a report on administrative charges to the Director of the Oregon Health Authority.

(2) The report will be posted on the Marketplace's website for public review and comment.

(3) At a minimum, the report will include:

(a) A projection of Marketplace operating expenses, including the Marketplace's share of the authority's shared services expenses and operating expenses borne by the Marketplace and reimbursed by another agency, based on the authority's budgets, assuming for this purpose that the operating expenses in any actual or expected biennial budget are distributed evenly over the biennium;
(b) A projection of Marketplace enrollment for the next calendar year; and
(c) A proposed administrative charge for the next calendar year.

(4) The authority will hold a public hearing on a proposed administrative charge.

(9) By the 30th day of September of every odd year, the department shall:

(a) Determine the maximum amount of funds that the authority may hold under ORS 741.105(3)(b) by calculating:
(A) The Marketplace's fund balance as of the end of the biennium immediately before the date by which the calculation is required to be made minus:
(B) One-fourth of the Marketplace's budgeted operating expenses for the biennium in which the calculation must be made as required by paragraph (9).

(b) Credit each individual carrier participating in the Marketplace an amount equal to the pro-rata share of any positive difference obtained from the calculation described in paragraph (9)(a) of this rule based on the total assessments the carrier reported to the department during the two-year period described in paragraph (9)(a)(A) of this rule plus the pro-rata share of the total assessments reported during the two-year period described in paragraph (9)(a)(A) of this rule by carriers no longer selling qualified health plans through the Marketplace.

(11) Except as provided in paragraph 12 of this rule, the authority shall apply the credit described in paragraph (9)(b) of this rule by reducing each monthly charge assessed during the period described in paragraph (9)(a)(B) by one-eleventh of the credit rounded to the nearest whole dollar beginning the first day of January following the date specified in paragraph (9) of this rule for 11 consecutive months. Any remaining credit rounded to the nearest whole cent shall be credited in the twelfth month.

June 26, 2026

2027 Marketplace Assessment

1

Welcome and Roll Call

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Meeting Guidelines

3

Meeting Protocols and Requests

- The Marketplace and the Health Insurance Marketplace Advisory Committee (HIMAC) are committed to safe and inclusive meetings for all attendees.
- We have differences of opinions and different experiences. There are no bad questions or silly ideas. We will seek the perspectives of all by inviting each person to speak.
- If you have a question or would like to comment, please raise your virtual hand or put your question in the chat.
- We have real-time Spanish interpretation. Please help by speaking at a moderate pace.
- Please be on camera as much and as often as you are comfortable and mute your speaker when not speaking.

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Meeting Protocols and Requests, Continued

- For transcribing and accessibility purposes, please state your name before speaking during the meeting.
- Members of the public are requested to hold questions and comments until the Public Comment portion/s of the meeting.
- If you are subjected to unacceptable behavior or witness unacceptable behavior during this meeting, please contact:
  Chiqui Flowers, Marketplace Director
  chiqui.l.flowers@oha.oregon.gov
  503-884-6017

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REMINDER: Compliance with Public Meeting Law

- As your name is called, please state your vote. Your vote will be logged in the meeting minutes.
- Public Meetings Law webpage:
  - oregon.gov/ogec/public-meetings-law/pages/default.aspx

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Approval of April 16, 2026 Meeting Minutes

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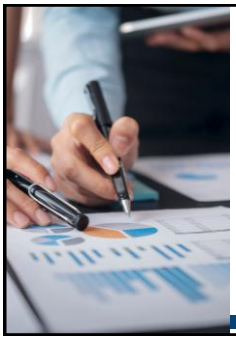

Overview of the Marketplace Assessment and Upcoming Changes

Chiqui Flowers
Director

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What is the Marketplace assessment?

A fee charged to health insurance companies that sell plans through the Marketplace.

Helps fund Marketplace operations, including:

- Consumer assistance
- Outreach and education
- Partner grants
- Technology
- Eligibility and enrollment systems
- Program administration
- Policy development

Used to help ensure Oregon is compliant with federal provisions and requirements for the exchange

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Role of the Committee

ORS 741.105. (1) The Oregon Health Authority shall establish, by rule, an administrative charge. The authority shall impose and collect the charge from all insurers participating in the health insurance exchange or offering a health plan certified by the authority and state programs participating in the health insurance exchange. **The Health Insurance Exchange Advisory Committee shall advise the authority in establishing the administrative charge.** The charge must be in an amount sufficient to cover the costs of grants to navigators, in-person assisters and application counselors certified under ORS 741.002 and to pay the administrative and operational expenses of the authority in carrying out ORS 741.001 to 741.540.

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Current Fee Structure

- State Assessment Fee
  - Oregon's Marketplace is funded through a per member per month fee on participating insurance companies.
- Federal Platform User Fee
  - Separate from the assessment fee
  - Paid directly by participating insurance companies to the federal government.
  - Charged as a percentage of premium, changes annually.

2026 Fees Using HealthCare.gov

Marketplace State Assessment For in-state policy development, plan management, outreach, education, training, escalated cases	0.93% of average premium
Federal Platform User Fee For website, CAC, and agent training	2% of average premium
Total	2.93%

2027 SBM Fees

SBM Fee = Marketplace State Assessment
For everything to be done in-state

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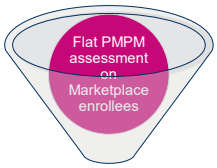
How Marketplace Carriers Incorporate the Fee

Insurance companies must spread the Marketplace assessment across the entire individual market, reducing the effective impact on any single enrollee.



Spead across direct and Marketplace enrollees

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Our Commitment to Transparency

Oregon is committed to transparency by charging a flat exchange user fee

- Federal policy changes have negatively impacted enrollment, resulting in lower enrollment and higher costs for the state to try to maintain or increase enrollment
- Oregon relies on enrollment stability to sustain funding because unlike a fee based on a percentage of premium, a flat fee does not increase at the high rate of medical inflation

HealthCare.gov charges a percentage of premiums

- When federal policy changes increase premiums, HealthCare.gov may maintain or increase revenue even if enrollment is negatively impacted
- Perceived reductions in fees do not necessarily equate to lower federal revenue or reduced costs for insurers and consumers

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Senate Bill 972 (2023)

Requires OHA to transition the Marketplace from a state-based marketplace using the federal platform (SBM-FP) to a state-based marketplace (SBM) using its own technology in time for open enrollment for plan year 2027.

- **Technology platform**
- **Call center**
- **Go live: Nov. 1, 2026**

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Groups Directly Impacted by the SBM Transition

- More than 118,000 enrollees
- 4 health insurance companies proposing to offer more than 40 plans
- 5 dental insurance companies proposing to offer more than 15 plans
- 700 licensed and certified insurance agents
- 1,600 certified enrollment assisters

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Enhanced Services with SBM Transition

- Improved shopping and customer service experience
- Local enrollment support and complex case resolution
- Tailored public outreach and education programs
- Local training, certification, and oversight for community partners and insurance agents
- Data accessibility to inform policy development
- Customized special enrollment periods
- Coordination with Oregon-based programs
- Flexibility to apply feedback in the long-term

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CY2027 Administrative Charges Oregon Health Insurance Marketplace Report For Health Insurance Marketplace Advisory Committee

CBIZ Optumas
Consultants • Actuaries • Economists

17

Overview

- Assessment Rate History
- Expenditures
- Assumptions
- Enrollment and Premium Projections
- Assessment Rates
- Revenue Estimates
- Summary
- Fund Balance

CBIZ Optumas

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Assessment Rate History

- Assessment rates increased moderately for 2026 to account for:
  - Lower enrollment due to Enhanced Premium Tax Credits (EPTC) expiration and implementation of the OHP Bridge.
  - Increased expenses related to transition to a state-based marketplace (SBM).
- The increase did not account for impacts from H.R. 1 or the 2025 Marketplace Integrity and Affordability Final Rule.

Marketplace Assessment Rates

	CY 2017 - CY 2019	CY 2020 - CY 2025	CY 2026	CY 2027
Medical PMPM	$6.00	$5.50	$6.85	TBD
Dental PMPM	$0.57	$0.36	$0.45	TBD

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Main Points (Spoilers!)

- We recommend an increase in the Medical Assessment rate to $35.60 and the Dental Assessment rate to $1.70.
- Expenses are projected to increase due to the State-based Marketplace (SBM) and because enrollment is forecasted to go down due to:
  - Expiration of Enhanced Premium Tax Credits (EPTC) and continued affordability issues.
  - Transitions to the OHP Bridge.
  - Withdrawal of some insurance carriers from the individual market.
- The assessments are charged to insurers who will transition payments away from the federal facilitated marketplace to the Oregon SBM.

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Expenditures

Marketplace Expenditures, Historical and Projected

CY 2022-2025 actuals and CY 2026-2027 forecast

	Marketplace Expenditures	Shared Services / SAEC	Total Expenditures
CY 2022	$6,071,063	$320,887	$6,391,950
CY 2023	$6,563,747	$936,474	$7,500,221
CY 2024	$6,958,386	$1,074,828	$8,033,214
CY 2025	$7,319,331	$1,360,893	$8,680,223
CY 2026	$14,889,794	$1,666,537	$16,556,331
CY 2027	* $33,924,962	$5,309,994	$39,234,956

SAEC - OHA Shared Assesment and Enterprise-wide Costs

*Expenditure increases in CY 2027 are a result of the transition to a state-based marketplace (SBM).

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Forecasting Effectuated Medical Plan Enrollment

- Create a Baseline Forecast using recent history
- Add impacts for known factors that will impact enrollment
  - Continuing impacts from the end of the Enhanced Premium Tax Credits (EPTC)
  - The impact of the OHP Bridge
  - The impact of insurer withdrawals from the individual market

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Not Included in the Forecast: Other Potential Risks

- Federal action on Medicaid
- Shorter open enrollment period
- Overall market uncertainty and volatility
- Other federal administrative choices
- Economic downturn

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Continuing Impacts of the End of the Enhanced Premium Tax Credit

- The Enhanced Premium Tax Credits (EPTC) expired at the end of 2025.
- Based on the most recent data (May 2026), between December 2025 and January 2026, effectuated enrollment fell from 125,800 to 109,500.
- Since January 2026, effectuated enrollment has continued to fall to 103,500.
- Most of the decrease has happened. However, continued affordability issue will continue to depress effectuated enrollment through 2026.

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Impacts of the OHP Bridge on Marketplace Enrollment

- People with incomes 138% - 200% FPL may be eligible for OHP Bridge.
- Assumes additional people have already started moving as early as July 2024.
- Assumes everyone eligible for the OHP Bridge currently on Marketplace plans are not forced to transition all at once.
- Preliminary analysis estimates at least an additional **3,150 decrease** in enrollments during the remainder of 2026.
- Estimate an **additional 2,850 decrease** in the first half of 2027.

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Impacts of insurers withdrawal from individual marketplace

- Two insurers withdrawing from Healthcare Marketplace: Providence and PacificSource
- They currently serve 34% of people in Marketplace
- Research indicates 7-12% increased likelihood of disenrollment when there are exits in the marketplace[1]
- A review of disenrollment in SBMs in 2026 compared states with withdrawals to those without withdrawals and found a 3% increase in disenrollment
- We estimate a 1-year decrease in the effectuated enrollment of 3%

[1] Crespin and DeLaire, "As Insurers Exit Affordable Care Act, So Do Consumers" (2019)

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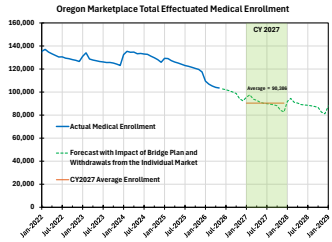
Medical Plan Enrollment



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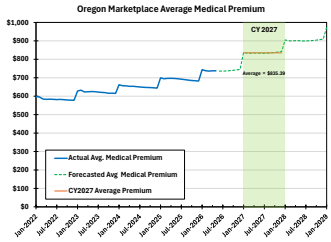
Average Medical Premiums



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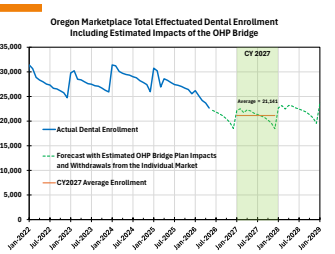
Stand-Alone Dental Enrollment



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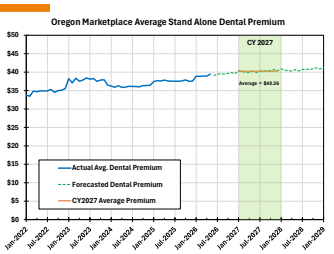
Dental Premiums



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Revenue Required from Medical Assessments

Total Expenditures for CY 2027: $39.2 Million

- $38.6 Million Medical Assessment Revenue with $35.60 assessment
- $431k Dental Assessment Revenue with $1.70 assessment
- $197k Interest Revenue from savings

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Sensitivity of Forecast Model

CY 2027 Revenue ($millions) by Assessment Rates

Medical Enrollment Forecast	PMPM assessment rates ($dollars)					Equlibrium Rates ($dollars)
	$25.00	$30.00	$35.60	$40.00	$45.00	
Forecast + 15,000	$31.6 mil	$37.9 mil	$45.0 mil	$50.6 mil	$56.9 mil	$30.53
Forecast + 10,000	$30.1 mil	$36.1 mil	$42.9 mil	$48.2 mil	$54.2 mil	$32.05
Forecast + 5,000	$28.6 mil	$34.3 mil	$40.7 mil	$45.8 mil	$51.5 mil	$33.73
Forecast = 90,386	$27.1 mil	$32.5 mil	$38.6 mil	$43.4 mil	$48.8 mil	$35.59
Forecast - 5,000	$25.6 mil	$30.7 mil	$36.5 mil	$41.0 mil	$46.1 mil	$37.68
Forecast - 10,000	$24.1 mil	$28.9 mil	$34.3 mil	$38.6 mil	$43.4 mil	$40.02
Forecast - 15,000	$22.6 mil	$27.1 mil	$32.2 mil	$36.2 mil	$40.7 mil	$42.68

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Federal Platform Fee

- Federally-facilitated Marketplace (FFM) user fees are separate from the assessment and are paid directly to the federal government.
- The FFM user fees will not be collected in Oregon in CY2027 due to the transition to the SBM. Insurers will transition payments away from the FFM to the Oregon SBM.
- The current state assessment of $6.85 PMPM is roughly 0.93 percent of the average premium for 2026. Carriers pay an additional 2% of premium for a combined SBM-FP fee of 2.93% of average premiums.

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Summary

*Assessment rate increases in CY 2027 to cover expenditure increases resulting from the transition to a state-based marketplace (SBM).

Medical Plans Summary, with Assessment Rate Assumptions

	2021	2022	2023	2024	2025	2026	2027
Average enrollment	126,217	131,135	127,100	132,045	123,789	101,689	90,386
% change	0.4%	2.3%	-3.1%	3.9%	-6.3%	-17.9%	-11.1%
Total premiums ($ millions)	$886.3	$919.3	$949.1	$1,032.1	$1,027.3	$901.4	$906.1
Avg premium	$576.02	$584.19	$622.39	$651.33	$691.38	$738.71	$835.39
% change	7.8%	1.4%	6.5%	4.7%	6.2%	6.8%	13.1%
Assessment rate	$5.50	$5.50	$5.50	$5.50	$5.50	$6.85	$35.60
Assessments ($ millions)	$6.5	$6.7	$6.4	$6.7	$8.2	$6.4	$38.6
Rate as % of avg premium	1.0%	0.9%	0.9%	0.8%	0.8%	0.9%	4.3%
Federal tech. charges ($ millions)	$15.5	$20.7	$21.4	$18.6	$12.3	$18.0	$0.0
Fed. as % of avg premium	1.75%	2.25%	2.25%	1.80%	1.20%	2.00%	0.00%

Dental Plans Summary

	2021	2022	2023	2024	2025	2026	2027
Average enrollment	26,367	27,664	27,759	29,039	27,745	22,260	21,141
% change	12.7%	4.9%	0.3%	4.6%	-4.5%	-19.8%	-5.0%
Total premiums ($ millions)	$10.6	$11.5	$12.6	$12.6	$12.5	$10.6	$10.1
Avg premium	$33.42	$34.75	$37.80	$36.15	$37.62	$39.51	$39.86
% change	-7.9%	4.0%	8.8%	-4.4%	4.1%	5.0%	0.9%
Assessment rate	$0.36	$0.36	$0.36	$0.36	$0.36	$0.45	$1.70
Assessments ($ millions)	$0.114	$0.120	$0.120	$0.125	$0.120	$0.120	$0.431
Rate as % of avg premium	1.0%	1.0%	1.0%	1.0%	1.0%	1.1%	4.3%
Federal tech. charges ($ millions)	$0.165	$0.260	$0.283	$0.227	$0.150	$0.211	$0.000
Fed. as % of avg premium	1.75%	2.25%	2.25%	1.80%	1.20%	2.00%	0.00%

Medical and Dental Combined

	2021	2022	2023	2024	2025	2026	2027
Total premiums ($ millions)	$896.8	$930.8	$961.7	$1,044.7	$1,039.8	$912.0	$916.2
Total assessments ($ millions)	$6.58	$6.77	$6.51	$6.84	$8.29	$6.48	$39.04
Total fed. Charges ($ millions)	$15.69	$20.94	$21.64	$18.80	$12.48	$18.24	$0.00
Assessment and fed. charges ($ millions)	$24.27	$29.72	$30.15	$27.64	$20.77	$26.72	$39.04
Total % of avg premium	2.7%	3.2%	3.1%	2.6%	2.0%	2.9%	4.3%

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Fund Balance

Summary of Financial Outcomes, Current Assessment Rates

	Total Expenditures	Total Revenue	Fund Balance
CY 2022	$6,391,950	$8,131,190	$8,240,013
CY 2023	$7,500,221	$9,395,352	$10,135,144
CY 2024	$8,033,214	$9,753,736	$11,855,666
CY 2025	$8,680,223	$8,788,055	$11,963,498
CY 2026	$16,556,331	$8,835,251	$4,242,418
CY 2027*	$39,234,956	$39,241,178	$4,248,640

*Expenditure increases in CY 2027 are a result of the transition to a state-based marketplace (SBM).

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Questions?

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Public Comment

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Next Steps and Voting

Victor Garcia

Marketplace Operations Advisor and Program Liaison

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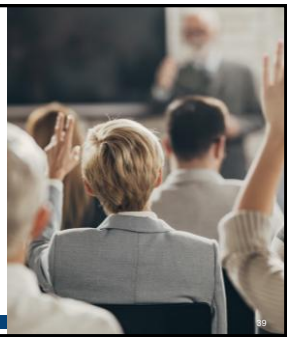
Feedback on Proposed 2027 Assessment

- Medical Assessment rate: $35.60
- Dental Assessment rate: $1.70

The change from the SBM-FP model to the SBM model is an estimated **increase of approximately 1.37% of average premiums** per member per month.



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Wrap Up

Next meeting:
July 16, 2026 (In person)

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Thank You

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