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MEMORANDUM

February 23, 2024

To: Chiqui Flowers, Director of the Oregon Health Insurance Marketplace, HPA, Oregon Health Authority
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Dave Baden, Deputy Director of Operations, Oregon Health Authority
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From: Caleb Lavan, Senior Manager, CBIZ Optumas

Subject: Oregon Health Insurance Marketplace Report – CY 2025 Administrative Charges Health Insurance Marketplace Advisory Committee Material

Issue

The Oregon Health Insurance Marketplace needs to determine assessment rates for Marketplace individual medical plans and for stand-alone dental plans for CY 2025. The current assessment rates are:

- $5.50 per member per month (PMPM) for individual medical health plans
- $0.36 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, a public hearing, and a decision on the assessment rates by March 31.

This memo provides information on Marketplace expenditures and possible enrollment patterns. These generate estimates of the assessment rates that would cover projected operational expenditures for the program. The memo also discusses the assessment rebate and the estimated costs of the federal technology.

Summary

- We use expenditure assumptions based on the Health Insurance Marketplace's 2023-2025 Legislatively Approved Budget (LAB). We also incorporate the Oregon Health Authority's (OHA) estimate of Marketplace shared service expenditures. Total expenditure for the 2023-2025 biennium are estimated to be $19.8 million.
- Preliminary data indicates CY 2025 will have a similar level of enrollment to CY 2024. For CY 2025, we assume a mostly flat caseload averaged over the year.
- Our analysis suggests that the current PMPM rates could be retained for CY 2025 to provide stable funding for the Marketplace.

Assessment rate history

The following table shows the recent history of the Marketplace assessment rates. The rates were $6.00 for CY 2017-19 and have remained at $5.50 since then.

Marketplace Assessment Rates

	CY 2017 - CY 2019	CY 2020 - CY 2024	CY 2025
Medical PMPM	$6.00	$5.50	TBD
Dental PMPM	$0.57	$0.36	TBD

Early on, 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 remains unchanged.

Current expenditure projections

The following table shows our current expenditure forecast. The figures are based on the 2023-25 Legislatively Approved Budget. It assumes the Marketplace's expenditures will be $18.8 million in the 2023-2025 biennium.

The agency's principal divisions and respective offices are charged for the central services costs they incur through an agency cost allocation. These include information technology (IT), financial, communications, and administrative services. These shared service costs are estimated to be $2.8 million in the 2023-2025 biennium.

Marketplace Expenditures,
Continuing Service Level Expenditures

FY 2016-2024 actuals and FY 2025-2027 forecast

	Marketplace expenditures	Shared services / SAEC	Total expenditures
FY 2016	$11,710,503	$474,266	$12,184,769
FY 2017	$4,570,408	$521,606	$5,092,014
FY 2018	$4,678,932	$945,702	$5,624,634
FY 2019	$5,924,885	$684,233	$6,609,118
FY 2020	$6,489,562	$667,378	$7,156,940
FY 2021	$4,714,893	$664,103	$5,378,996
FY 2022	$5,113,191	$353,518	$5,466,709
FY 2023	$5,163,299	$431,662	$5,594,961
FY 2024	$7,432,709	$1,299,868	$8,732,577
FY 2025	$8,495,482	$1,529,187	$10,024,669
FY 2026	$8,750,347	$1,575,062	$10,325,409
FY 2027	$9,012,857	$1,622,314	$10,635,171

FY 2024 contains two quarters of actual expenditures
FY 2025 and FY 2026 do no include any costs for the SBM transition
SAEC - OHA Shared Assesment and Enterprise-wide Costs
Note: Assumes 3% increase in Expenditures per year for forecasted years

The table shows actual expenditures for FY 2019 - FY 2024. The FY 2019 expenditures were lower because of refunds due to telecommunications and IT contracts.

The FY 2022 shared services expenditures were lower due to the twelve-month transition from Department of Consumer and Business Serves (DCBS) to the Oregon Health Authority.

The FY 2024 figures are based on actual expenditures through December 2023 and projected expenditures taken from the 2023-25 Legislatively Approved Budget (LAB) for the final six months of FY24.

The FY 2025 expenditures are taken from the 2023-2025 Legislatively Approved Budget (LAB).

For FY 2026 and FY 2027, we use the FY 2025 expenditures and assume a three percent natural growth rate in expenditures per year.

Marketplace medical-plan enrollment forecast

The assessment rate needed to fund the Marketplace's operations depends on the forecast of individual medical-plan enrollment. In past years, the advisory committee has discussed being cautious and assuming that federal changes might lead to a significant decline in enrollment. That has not materialized. Preliminary results for January and February of 2024 show enrollment very close to 2023.

Our forecast uses the preliminary estimate for January and February of 2024 as a starting point. There is significant volatility in carriers' reported enrollment. The following table shows reported January enrollment between 2019 and 2024. Carriers are allowed to revise enrollment for up to 18 months. Some years the variation is larger than other years. Careful examination of

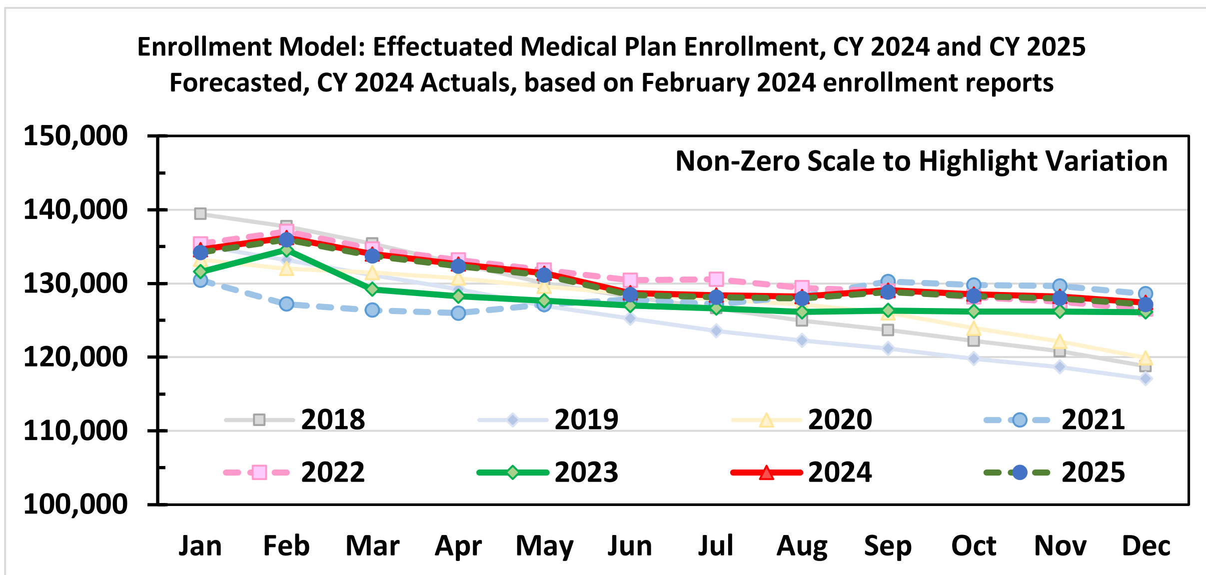
the data shows that the variation is often driven by missing data from particular carriers, although most carriers do show some variation on the January caseload over time.

January Enrollment for Different Insurer Submission Dates

	January submission	February submission	March submission	December submission	Final
January-2018	123,637	141,769	141,059	140,172	139,415
January-2019	127,391	140,995	140,905	135,141	135,113
January-2020	111,606	141,491	133,181	133,292	133,228
January-2021	143,854	120,345	127,983	130,432	130,432
January-2022	125,770	125,981	140,438	135,352	135,365
January-2023	116,828	116,509	132,890	131,591	
January-2024	114,666	113,615			

Some carrier data was missing for January 2024 leading to particularly low initial numbers, but February 2024 captured some of those numbers. February's unadjusted enrollment for 2024 was 133,780. I went through and adjusted each carrier's individual caseload numbers for January and February 2024 based on the historical trends found in the revision patterns in previous years.

I estimated 134,596 for January 2024 and 136,209 for February 2024. With those values as the starting point for the CY 2024, I then applied an exponential smoothing model to the period from January 2021 to February 2024. This captures the recent pattern of enrollment during the Public Health Emergency. The average growth in the years ahead is estimated to be about -0.2 percent. It is also forecasted to have less seasonal variation than in the period before the pandemic.



Discussion of Factors Impacting the Medical Plan Enrollment Forecast.

There are a number of factors that may impact the medical plan enrollment in CY 2025. They include the Bridge plan, Medicaid unwinding, the premium supports in the Inflation Reduction Act (IRA), the open enrollment period, and the economy.

We will address each of them in turn. They can push the forecast up or down, but they are difficult to quantify. Overall, I judge the impact to be roughly balanced and in CY 2025, we have not factored in any direct impacts to the forecast.

The OHP Bridge (also called the Basic Health Plan) will extend Medicaid eligibility to 200% FPL. Since the Marketplace currently covers people with eligibility from 138% FPL and up, the expanded eligibility under the Bridge Plan is expected to cut into Marketplace enrollment. However, much of the potential impact is already baked into the current enrollment. Most people who are Medicaid eligible have made it onto the Medicaid caseload over the last 3 years. With the no adverse actions rule during the pandemic, even people who's income grew over 138% remained on the Medicaid caseload. The most recent CMS Marketplace Report does show some enrollees with incomes between 138% and 200% FPL. However, that data on enrollees' income may be lagged or out of date. I expect the overall impact to be modest to small.

Medicaid Unwinding is the end of the period of no adverse actions and the resumption of case closures for all Medicaid cases. HB 4035 mandates that OHA reduce the loss of insurance during this period. Case closures began in October 2023 and are expected to continue for roughly 15 months. Since October, Medicaid caseloads have been decreasing, but not yet to the degree that was expected. The impact on the medical plan enrollment was expected to push enrollment up as people leave Medicaid and potentially enroll through the exchange. In practice, there is little to no visible impact on the exchange enrollment starting in October 2023.

The Inflation Reduction Act (IRA) provides additional subsidies to those on the Marketplace. The average recipient receives $800 in additional subsidies according to the US Department of Health and Human Services.[1] This provision of the law is set to sunset in 2025. Less generous subsidies after that date can be expected to put downward pressure on caseloads.

The open enrollment period causes a significant increase in the number of new enrollees. That is a federal administrative choice and is subject to change. An increase or decrease to the length of the open enrollment period could increase or decrease the caseload.

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 is strong, and unemployment is 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. The overall impact may be mixed.

Individual medical plan assessment rates

[1] On the First Anniversary of the Inflation Reduction Act, Millions of Medicare Enrollees See Savings on Health Care Costs, August 16, 2023., accessed on 2/8/2024. https://www.hhs.gov/about/news/2023/08/16/first-anniversary-inflation-reduction-act-millions-medicare-enrollees-savings-health-care-costs.html#:~:text=The%20Inflation%20Reduction%20Act%20extends,%24800%20in%20premiums%20per%20year
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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 130,337 members. An assessment rate of $5.50 PMPM would generate $8.6 million in revenue. With the same enrollment, a $5.25 PMPM would generate $8.2 million. If the average enrollment were 10,000 a month lower than forecast, the $5.50 PMPM would generate $7.9 million; if the enrollment were 10,000 a month higher, the $5.50 PMPM would generate $9.3 million.

CY 2025 Revenue Assessment Rates

Medical Enrollment Forecast	PMPM assessment rates					Equlibrium Rates
	$6.00	$5.75	$5.50	$5.25	$5.00	
Forecast + 15,000	$10.5	$10.0	$9.6	$9.2	$8.7	$5.59
Forecast + 10,000	$10.1	$9.7	$9.3	$8.8	$8.4	$5.79
Forecast + 5,000	$9.7	$9.3	$8.9	$8.5	$8.1	$6.00
Forecast = 130,337	$9.4	$9.0	$8.6	$8.2	$7.8	$6.23
Forecast - 5,000	$9.0	$8.6	$8.3	$7.9	$7.5	$6.48
Forecast - 10,000	$8.7	$8.3	$7.9	$7.6	$7.2	$6.75
Forecast - 15,000	$8.3	$8.0	$7.6	$7.3	$6.9	$7.04

In our financial modeling, we define the "equilibrium rate" as the assessment rate needed to cover one year of expenditures. Using the expenditures described above, we take the average of the FY 2025 and FY 2026 expenditures to estimate the CY 2025 planned expenditures. They are about $10.2 million. The dental plan assessment is estimated to raise $131,000 and investment income will generate about $300,000, for a total of $431,000, so the medical plan assessment will need to generate about $9.74 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 $6.23 PMPM. If monthly enrollment were 5,000 higher, the equilibrium rate would be $6.00 PMPM.

Stand-alone dental plan enrollment and premiums forecast

Dental plan enrollment was reasonably steady for the two years before the Public Health Emergency. However, starting in March of 2020 it has shown significant growth, roughly 5 percent in 2020 and 2023 and 12 percent in 2021. We do expect continued growth. Initial data for January of 2024, though incomplete, is larger than January 2023. Although recent growth has not been steady from year to year it has shown a definite upward trend. That is captured by our exponential smoothing model, which forecasts moderate growth in the standalone dental enrollment for the next few years.

Dental premiums have not shown consistent growth in the last 6 years. However, the growth in dental premiums has been more consistent in the last 3 years. We forecast that trend will continue with a $0.50 increase per year in dental premiums over the next several years. Most recently (CY 2023), it was $35.57. We assume $36.5 as the average premium for the CY 2025 forecast period.

Statutory cap on the Marketplace account balance

The statutory cap previously outlined in ORS 741.105 was removed by SB 972 in the 2023 session.

Federal exchange technology charges

The federal technology charges are separate from the assessment and are paid directly by insurers to the federal government. Therefore, they affect neither revenue nor expenditures. In CY 2024, the federal technology charge was reduced to 1.8 percent of premium for State-based Marketplaces on the Federal Platform (SBM-FP). We assume it will be 1.8 percent in 2025 as outlined in the proposed HHS Notice of Benefit and Payment Parameters for 2025.

Enrollment forecast summary

The following table provides a summary by calendar year using the current assessment rates, the proposed enrollment forecast, the Legislatively Adopted Budget expenditures and assumed federal technology charges. The table includes the forecast average premium for medical policies. We have assumed the increase will be 3.4 percent in CY 2024 and roughly that amount in future years as well.

The table also shows our stand-alone dental plan forecast. The dental plan premiums have jumped around in a fairly narrow band but have been trending upwards for the last 3 years. We have assumed a slow growth in the rate for the average stand-alone dental plan premium.

Medical Plans Summary, with Assessment Rate Assumptions

	2020	2021	2022	2023	2024	2025	2026	2027
Average enrollment	127,715	128,217	131,135	127,990	130,619	130,337	130,065	129,794
% change	1.9%	0.4%	2.3%	-2.4%	2.1%	-0.2%	-0.2%	-0.2%
Total premiums ($ millions)	$818.6	$886.3	$919.6	$956.0	$1,013.5	$1,046.2	$1,079.2	$1,112.0
Avg premium	$534.12	$576.02	$584.39	$622.42	$646.60	$668.88	$691.42	$713.96
% change	-7.3%	7.8%	1.5%	6.5%	3.9%	3.4%	3.4%	3.3%
Assessment rate	$5.50	$5.50	$5.50	$5.50	$5.50	$5.50	$5.50	$5.50
Assessments ($ millions)	$8.4	$8.5	$8.7	$8.4	$8.6	$8.6	$8.6	$8.6
Rate as % of avg premium	1.0%	1.0%	0.9%	0.9%	0.9%	0.8%	0.8%	0.8%
Federal tech. charges ($ millions)	$20.5	$15.5	$20.7	$21.5	$18.2	$18.8	$19.4	$20.0
Fed. as % of avg premium	2.50%	1.75%	2.25%	2.25%	1.80%	1.80%	1.80%	1.80%

Dental Plans Summary

	2020	2021	2022	2023	2024	2025	2026	2027
Average enrollment	23,399	26,367	27,664	27,862	28,994	30,361	31,720	33,080
% change	5.4%	12.7%	4.9%	0.7%	4.1%	4.7%	4.5%	4.3%
Total premiums ($ millions)	$10.2	$10.6	$11.5	$11.9	$12.5	$13.3	$14.1	$14.9
Avg premium	$36.28	$33.42	$34.75	$35.57	$36.00	$36.50	$37.00	$37.50
% change	-7.3%	-7.9%	4.0%	2.3%	1.2%	1.4%	1.4%	1.4%
Assessment rate	$0.36	$0.36	$0.36	$0.36	$0.36	$0.36	$0.36	$0.36
Assessments ($ millions)	$0.101	$0.114	$0.120	$0.120	$0.125	$0.131	$0.137	$0.143
Rate as % of avg premium	1.0%	1.1%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Federal tech. charges ($ millions)	$0.255	$0.185	$0.260	$0.268	$0.225	$0.239	$0.254	$0.268
Fed. as % of avg premium	2.50%	1.75%	2.25%	2.25%	1.80%	1.80%	1.80%	1.80%

Medical and Dental Combined

	2020	2021	2022	2023	2024	2025	2026	2027
Total premiums ($ millions)	$828.8	$896.8	$931.1	$967.9	$1,026.0	$1,059.5	$1,093.2	$1,126.9
Total assessments ($ millions)	$8.53	$8.58	$8.77	$8.57	$8.75	$8.73	$8.72	$8.71
Total fed. Charges ($ millions)	$20.72	$15.69	$20.95	$21.78	$18.47	$19.07	$19.68	$20.28
Assessment and fed. charges ($ millions)	$29.25	$24.27	$29.73	$30.34	$27.21	$27.80	$28.40	$28.99
Total % of avg premium	3.5%	2.7%	3.2%	3.1%	2.7%	2.6%	2.6%	2.6%

Marketplace financial outcomes

The following table summarizes the forecast financial outcomes with the current assessment rates. The FY 2019 – FY 2023 figures are actual revenue and expenditures. The FY 2020 credit of $4.2 million was credited to insurers during CY 2021.

The FY 2024 – FY 2026 figures show the forecast if the enrollment and expenditure assumptions are correct. The revenue figures reflect the assessment revenue and investment revenue. If expenditures for CY 2025 are at the maximum set by the Legislatively Approved Budget, and the enrollment is at the annual average of 130,337, then the revenue will be slightly less than expenditures. However, there is more than enough cash in the Fund Balance to handle any potential shortfall. If expenditures are less than approved in the LAB, the Fund Balance would continue to grow through CY 2025.

Summary of Financial Outcomes, Current Assessment Rates

	Total Expenditures	Total Revenue	Fund Balance
FY 2018	$5,624,634	$9,323,616	$5,625,780
FY 2019	$6,609,118	$9,600,190	$8,616,852
FY 2020	$7,156,940	$7,006,713	$8,466,625
FY 2021	$5,378,996	$6,452,569	$5,740,198
FY 2022	$5,466,709	$8,034,260	$8,307,749
FY 2023	$5,594,961	$7,454,163	$10,166,951
FY 2024	$8,732,577	$9,046,102	$10,480,476
FY 2025	$10,024,669	$9,033,387	$9,489,193

SB972, as enrolled in 2023, amends ORS 741.105 and allows the Oregon Health Insurance Marketplace to hold and use excess moneys collected to offset future net losses. This eliminates the requirement to refund any fund balance greater than 6 months of operating costs.

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.