Oregon Health Insurance Marketplace Advisory Committee Meeting
June 20, 2025
1:05 – 2:25 p.m.

Virtual
Click here to join the meeting
(You can choose to have the meeting call you)
Phone: 669-254-5252
Access code: 160 662 5462#

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.

A G E N D A

Time	Agenda Item	Facilitators and Presenters	Purpose
1:05 – 1:10 p.m.	Welcome, meeting guidelines, and approval of previous meeting's minutes	Nashoba Temperly Committee Vice Chair	Information and voting
1:10 – 2:00 p.m.	Proposed 2026 Marketplace assessment analysis	Caleb Lavan Senior Manager Myers and Stauffer	Information
2:00 – 2:05 p.m.	Public comment	Nashoba Temperly Committee Vice Chair	
2:05 – 2:15 p.m.	Next steps and voting	Victor Garcia Marketplace Operations Advisor and Program Liaison	Information and voting
2:15 – 2:25 p.m.	Wrap up and closing	Lindsey Hopper Committee Chair	

*As approved in the 2025 committee workplan on 10/12/2024.

Health Insurance Marketplace Advisory Committee Meeting Minutes

DRAFT

When: Thursday, April 17, 2025 – 9 a.m. to 12:00 p.m.
Where: Virtual via Microsoft Teams
In-person at the Barbara Roberts Human Services Building
500 Summer St NE Rm 160, Salem OR 97301

Committee members:
Virtual – Gladys Boutwell, Stacy Carmichael, Charlie Fisher, Ron Gallinat, Paul Harmon, Lindsey Hopper (chair), Shannon Lee, Kathleen Orrick, Clare Pierce-Wrobel, Andrew Stolfi, Om Sukheenai, Nashoba Temperly (vice chair), Joann ZumBrunnen

Members not present: None

Other presenters: Stephanie Kennan, Dorocida Martushev, Sean McAnulty, Marybeth Mealue, Tim Sweeney

Marketplace staff: Katie Button, plan management and policy analyst; Amy Coven, communications and public engagement analyst; Chiqui Flowers, director; Victor Garcia, operations development specialist; Cable Hogue, implementation analyst and federal liaison; Dawn Shaw, office support coordinator

Agenda item and time stamp*	Discussion

Welcome, roll call, guidelines, approval of minutes, new member introduction	Roll call of Health Insurance Marketplace Advisory Committee (HIMAC) members, review of meeting guidelines, and approval of the 12/5/24 meeting minutes. (See the handout packet pages 1-2 for a copy of the agenda, pages 3-6 for the December minutes, and page 7 for meeting protocols.)
	• Approved December 5, 2024, minutes.
	  ○ First motion to approve – Kathleen Orrick
	  ○ Second motion to approve – Shannon Lee
	  ○ Ayes – Gladys Boutwell, Stacy Carmichael, Charlie Fisher, Ron Gallinat, Paul Harmon, Lindsey Hopper, Shannon Lee, Kathleen Orrick, Clare Pierce-Wrobel, Andrew Stolfi, Om Sukheenai, Nashoba Temperly, and Joann ZumBrunnen
	  ○ Nays – none
	• Introduced our new member, Joann ZumBrunnen. She is a small business owner and a Marketplace enrollee.

Federal health policy updates
13:10
	Presenter: Stephanie Kennan from McGuire-Woods Consulting.
	• A lot is going on with the new administration. What has happened so far:
	  ○ Some Executive Orders went out that reversed some Biden-era policies.
	  ○ 2025 Marketplace Integrity and Affordability Rule has been proposed.
	  ▪ Would shorten the open enrollment period.
	  ▪ Requires enhanced income verification process

        - Reinstates a 2015 policy that would require Marketplaces to designate enrollees as ineligible for APTCs (advanced premium tax credit) if they fail to reconcile on their taxes.
        - Makes it so states cannot automatically reenroll bronze members if they are eligible for a cost-sharing reduction (CSR) silver plan.
        - Changes SEPs (special enrollment periods), including removing the 150% FPL (federal poverty level) for a month or two.
        - Bars DACA (Deferred Action for Childhood Arrivals) recipients from QHPs (qualified health plan) and BHPs (basic health plan) making them ineligible for APTCs and CSRs.
        - Removes gender affirming care as an essential health benefit and allows insurers to collect past due premiums before they can move to another plan if state law permits.
        - Some injunctions have already been filed and are noted in the rule.
- CMS (Centers for Medicare and Medicaid Services) is reinstating agents or brokers that were kicked out due to churn or enrolling people without their knowledge. Stating that they were removed without due process.
- In the final MA (Medicare Advantage) rule, HHS (Health and Human Services) is denying coverage of weight loss medications. Under Biden, obesity was considered a chronic illness.
    - US Preventative Services Task Force is reviewing weight loss drugs. The result could be that private insurance is required to cover the weight loss drugs.
- HHS cuts:
    - 300 people cut from CMS. It is not clear which section of CMS they were working.
    - Over 20,000 HHS employees have been let go across the country.
    - Most changes are to consolidate functions.
    - Reducing the CDC (Centers for Disease Control) data collection functions.
    - A lot of cuts made in the FDA (Food and Drug Administration).
    - They will be consolidating Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA).
    - Regional offices will be reduced from 10 to 5. Those that will be closed are Boston, New York, Chicago, San Francisco, and Seattle. Offices that will remain are Philadelphia, Denver, Kansas City, Atlanta, and Dallas.
    - June 2 deadline to make all the cuts. Some agencies have rehired people on a temporary basis to perform duties no one else can do.
    - New CMS administrator is Dr. Oz, he is focusing on AI (artificial intelligence) to help with waste, fraud, and abuse. Some discussions on using AI for administering healthcare.
- Budget resolution and reconciliation:
    - The resolution is not a law, and not signed by the president. It is an outline on Congress' priority for spending.
    - Reconciliation needs a majority to pass.
    - Byrd Rule is that Congress must review the package and make sure that it is directly impacting spending, up or down.
    - Enhancing child tax credit, no taxes on tipping or social security benefits. Discussion on taxing high income earners.
    - PBM (pharmacy benefit management) reform is a topic of interest.
    - Discussion on reversing the Biden administration nursing home rule.

    - They believe that states are getting too much money and qualifying people at 90% of the FMAP (federal medical assistance program). Looking at reducing the FMAP and having more eligibility verifications.
    - APTCs will expire at the end of the year. It is unclear about extending and hard to predict what will happen.
- Om commented on the proposed bill about people choosing a bronze plan if they are eligible for a silver plan and at the same time talking about APTC ending. Some people can't afford to pay for a CSR silver plan.
- Stephanie added is when they are looking to unwind some programs, they are talking about expanding the contracts with the states and not considering the added expense to the states.
- Om has been approached by lobbyists and wonders if it is worth it. Stephanie stated that if you have a particular point of view, lobbying is a way to make some noise and having your voice heard.
- Kathleen observed that the states where the regional offices appear to be cut are blue states and the remaining states are red and wondered if this was an accurate observation. Stephanie confirmed that observation has been brought up, but the usual response is that they are just consolidating.
- Kathleen also wondered how the public will be served with the consolidation. Stephanie stated that there are conversations about if the remaining regional office will be able to support the work.
- Kathleen brought up that Robert F. Kennedy is talking about eliminating obesity treatments which has a link to other comorbidities and at the same time, discussing a cure for autism.

OHP Bridge updates
44:47

Presenters: Sean McAnulty, OHP (Oregon Health Plan) Member Communications Coordinator and Tim Sweeney, HPA (Health Policy and Analytics) Senior Policy Analyst.
(See pages 8-10 of the handout packet for a copy of the slide deck)

- Paul wondered what if something happens to the Bridge program if there are Medicaid cuts. Tim responded that right now, they don't know what is going to happen. It depends on what is cut. The Bridge program, while operated through Medicaid and CCOs (coordinated care organizations), is funded through the Marketplace and they will continue to monitor the situation.
- Om is concerned about the mandatory language about ending their Marketplace plan if they qualify, but some clients don't want to be in OHP, and if they still have that option. Tim replied that they are not able to tell clients that because federally they are not eligible for a Marketplace plan if they have OHP. They can passively reenroll if they don't update their plan from year-to-year.
- Charlie thinks that it can be challenging for people when they get a bill to have them request retroactive coverage. In future years, can we come up with a more streamlined solution. Tim informed that there are some limitations that would not enable an automatic back date of coverage for everyone that enrolls in February to April. Not able to identify people who have a coverage gap.
- Kathleen questioned if people are getting notices well in advance of their eligibility ending and that reenrollment is necessary. Sean said that they will get notification a few months in advance that their benefits will end if they don't respond about their OHP renewal.

SBM project updates
1:06:18

Presenters: Victor Garcia, Marketplace Operations Development Specialist and Dorocida Martushev, SBM (State-based Marketplace) Project Manager.
(See pages 7-8 of the handout packet for a copy of the slides.)

- Charlie asked and Dorocida responded.

	○ Q: Which vendor we are going with? ○ A: GetInsured ○ Q: How was the decision made? ○ A: There was a formal approval process involving DAS (Department of Administrative Services), DOJ (Department of Justice) and Procurement. It is a structured process with scoring methodology when we reviewed the proposals. The information can be located on Oregon Buys. There were demos of the proposed product. ○ Q: What is the protest and what is the significance. ○ A: After we posted in Oregon Buys the intent to award, there was a seven-day protest period. Chiqui added that DAS released a response to the protest this week. • Stacey wondered if there were any themes during the partner listening sessions and if any action was taken. Dorocida replied that she doesn't have that information, but it is available on the SBM Project website, including recordings of the sessions. Chiqui will be following up on this question after the meeting.
Public comment & break 1:29:25	John-Pierre Cardenas from Kaiser Permanente appreciated our updates Q: Is there an expected target kick-off date selected for issuers to begin integration discussions so as a carrier we are prepared. A: Dorocida responded that we anticipate the vendor selection process will be at the end of July. We will be putting together a timeline and should be able to have a more definitive date. Victor added that Katie Button and Anthony Behrens are reaching out to carriers to get their company's IT contacts. Chiqui advised that there is a carrier listening session on April 24.
2025 open enrollment progress report 1:37:46	Presenter: Cable Hogue, Marketplace Implementation Analyst and Federal Liaison. (See pages 10-11 of the handout packet for a copy of the slide deck) • Cable provided a caveat that the public use files have not yet been released by CMS. We were given permission to use internal numbers. There may be some differences when the data is released to the public.
2026-2027 Carrier Request Applications 1:41:54	Presenter: Katie Button, Marketplace Plan Management and Policy Analyst. (See page 12 of the handout packet for a copy of the slide deck) • Kathleen is concerned about providers available but not actually offering and approving services because they don't have contracts in the members area. Katie explained that there is not a lot that the state can do, but they are required to show network adequacy with DFR (Department of Financial Regulation). Carriers and providers must come to contract together. Chiqui will be looking into this and will follow up. Kathleen added that there is a carrier on slide 42 who doesn't have a robust network in the Eastern Oregon area. • Om asked if there is a customer service rating system. Medicare has a star rating system. Can DFR not contract with them due to poor customer service? Katie replied that they don't ask about customer service directly but ask about overall customer interactions. Carriers must be in good standing with DFR. If they are not in good standing, DFR will not certify the plan. • Joann shares the concerns as well and would like further discussion about health care contracts and not providing payment. Chiqui will be following up with Joann about her concerns. Joann had another question on if the HIMAC's goal is to make sure there are enough choices for consumers. Katie stated that most of our

	carriers are Oregon-based and that is why we have so many insurers to chose from.
2025 Marketplace Integrity & Affordability proposed rule 1:55:08	Presenter Anthony Behrens, Marketplace Senior Policy Advisor. (See pages 13-14 of the handout packet for a copy of the slide deck) • No additional questions were asked.
2025 legislative bills of interest 2:10:42	Presenter: Marybeth Mealue, Senior Policy Advisor with OHA (Oregon Health Authority) Government Relations. (See pages 14-15 of the handout packet for a copy of the slide deck) • HP 3964 is not on slide 58 as it was introduced yesterday (April 16, 2025). It creates a process for health insurers or providers to choose to mediate when they are not able to come to an agreement on contract negotiations. Gives the Governor decision making authority and creates penalties if they cannot come to an agreement. Not reviewed or sent to a committee yet. • Stacey had a question about SB 822. Earlier in the meeting, there was discussion on network adequacy and if SB 822 addresses those questions. Marybeth clarified that SB 822 is focused on large employee health group plans, like PEBB (Public Employees Benefit Board). Currently fiscal is evaluating the bill and will be a part of the May revenue forecast. • Om wanted to know about SB 2540, which has been passed to the floor of first chamber, and wanted to know what kind of treatments will be affected. Marybeth clarified that it is not specific, but situational.
SBM branding initiative 2:21:16	Presenter: Amy Coven, Marketplace Communications and Public Engagement Analyst. (See pages 16-17 of the handout packet for a copy of the slide deck) • Stacey appreciates the work and her favorite is “Explore Health”. She liked “Chorus” once it was explained but may have to be explained for the consumers to understand. • Shannon loved the layers and loves “Explore Health”. • For Charlie, “Explore Health” is the favorite. Speaks to where someone could go to get health insurance. “To Your Health” and “Chorus” aren’t as intuitive and doesn’t look like it would be for health insurance. • Kathleen echoes that “Explore Health: is her favorite. It is intuitive and would resonate with Oregonians. • Amy added that Lindsey and Nashoba are two of the sponsors and have given great feedback. • Chiqui wanted the committee to know if they have any suggestions, comments, or questions please do not hesitate to reach out to her and Amy.
Public comment, committee business, wrap up and closing	• John-Pierre Cardenas really appreciated the presentation. Kaiser is eager to see the exchange evolve. Wanted to know if there will be an email or something that will go out on topics the Marketplace wants comments on. Chiqui suggested going to the SBM website orhim.sbm/transition and signing up for one of the listening sessions or getting on the newsletter distribution list. Katie can be a point of contact for carrier concerns. • Follow up topics will be done through email or at the next meeting.

2:41:57	○ Charlie on evaluation criteria ○ Stacey on partner listening sessions and any actions taken from that feedback. ○ Kathleen & Joann about provider contracting and network adequacy. • This is the last meeting we will have with DCBS ex-officio Andrew Stolfi. He is going to work at the Oregon Employment Department in June. In the interim, direct any DFR questions to Chiqui. • Next meeting will be the Assessment Rate Rule hearing on June 18, 2025.

*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 2025 Meetings, April 17.

MEMORANDUM

June 20, 2025

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 2026 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:

- $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, 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 2026 will have a lower level of enrollment than CY 2025, due to impacts from Oregon Health Plan (OHP) Bridge and the end of the enhanced premium tax credits (EPTC).
- Our analysis suggests that the PMPM rates need to be increased to $6.85 for individual medical health plans and $0.45 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 have remained at $5.50 since CY2020.

Marketplace Assessment Rates

	CY 2017 - CY 2019	CY 2020 - CY 2025	CY 2026
Medical PMPM	$6.00	$5.50	TBD
Dental PMPM	$0.57	$0.36	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 remains unchanged.

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. The latest estimates were transmitted by email on 06/06/2025.

Marketplace Expenditures, Historical and Projected

CY 2022-2024 actuals and CY 2025-2026 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	$7,984,016	$1,374,129	$9,358,145
CY 2026	$8,549,394	$1,538,891	$10,088,285

SAEC - OHA Shared Assesment and Enterprise-wide Costs

The table shows actual expenditures for CY 2022 - CY 2024.

Actual expenditures were available through April 2025 and projected expenditures from May 1, 2025 forward were taken from the expenditure estimates provided by staff.

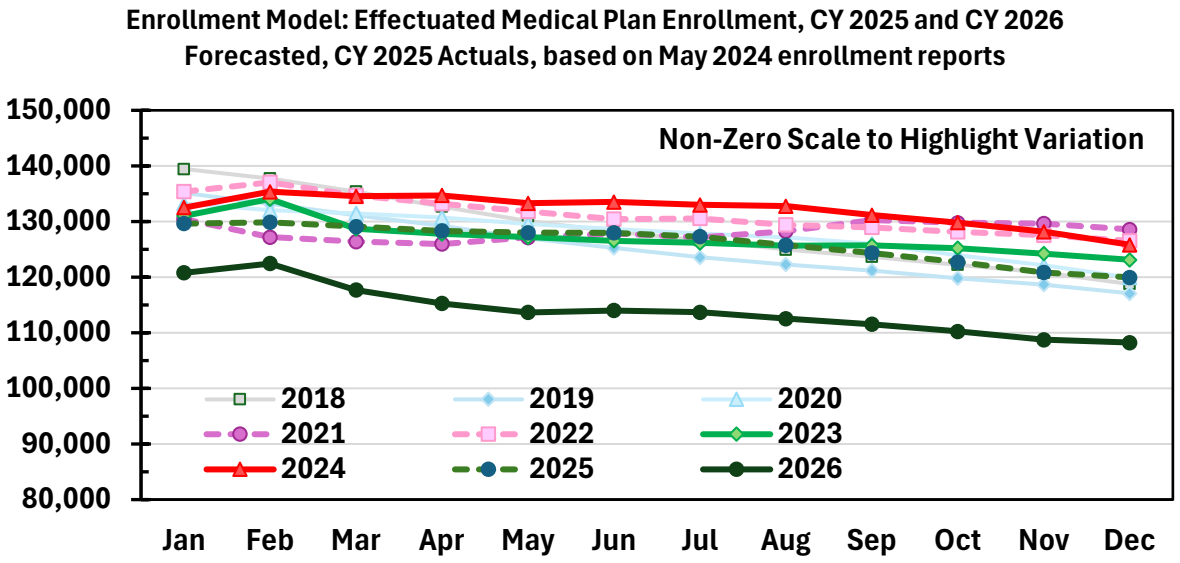
Marketplace medical plan enrollment forecast

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 2025. 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 127,992 enrollees for May 2025. With that value and the stable enrollment numbers from January to April of 2025 as the starting point for the CY 2025, we then applied a seasonal exponential smoothing model to the period from January 2022 to May 2025. 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 numbers are distinctly lower. That is due to some of the anticipated changes expected to impact the medical enrollment. We will discuss those next



Discussion of factors impacting the medical plan enrollment forecast

There are a number of factors that may impact the medical plan enrollment in CY 2026. The two that will have the largest impact are enrollees transferring to OHP Bridge and the end of the enhanced premium tax credits ("No EPTC") in the Inflation Reduction Act (IRA). Other factors that could impact medical enrollment but were not directly accounted for in the model include changes to the open enrollment period, changes in federal legislation and guidance, and the state of the economy. We will discuss the first two, which were modeled in the forecast and then we will address the other risks that were not modeled in the forecast.

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.

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

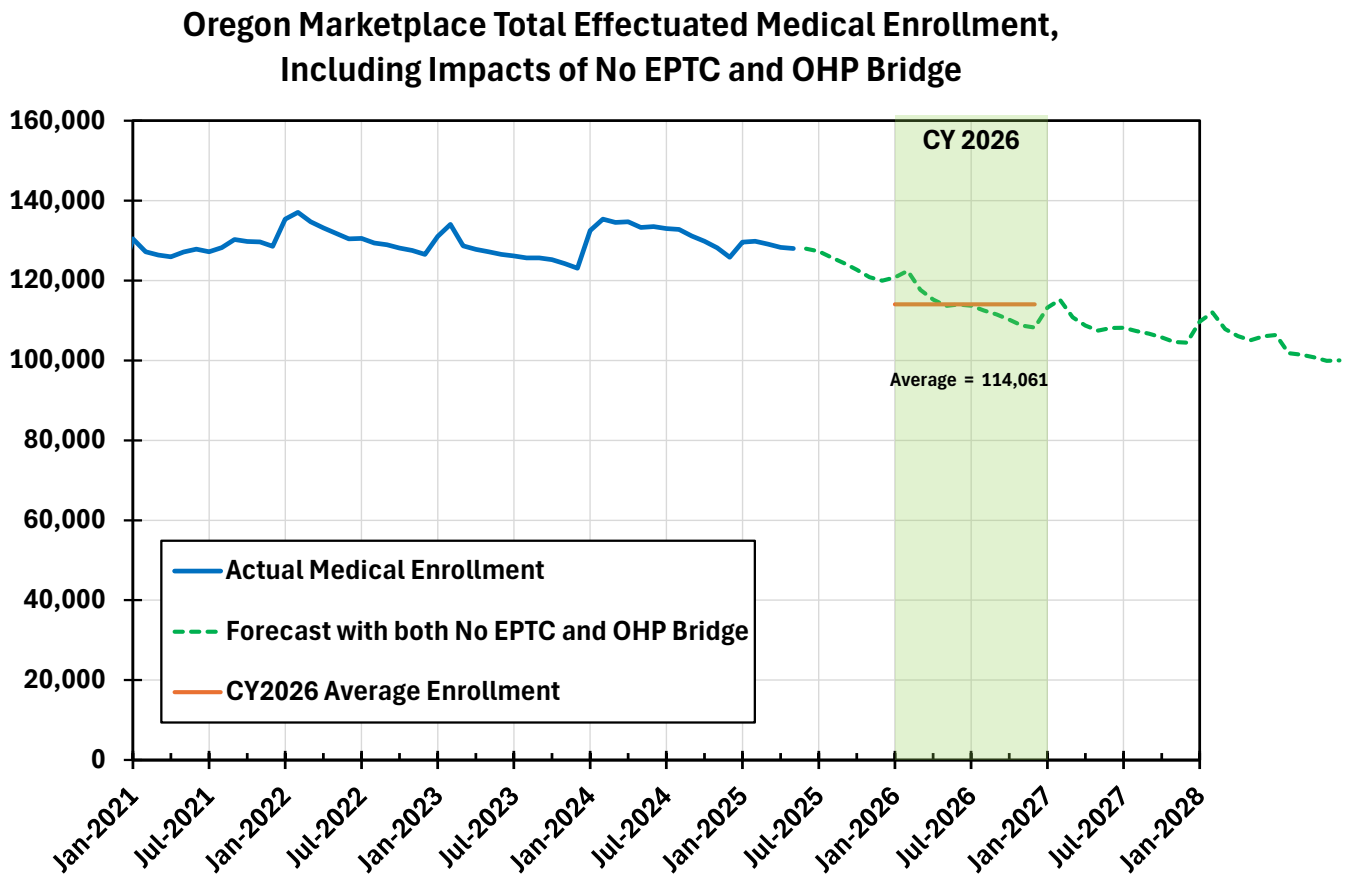
Enhanced premium tax credits were implemented during the pandemic and extended through 2025 to provide greater access to affordable health insurance. These tax credits were used to reduce the insurance premiums that members of Marketplace pay based on income. The average recipient receives $800 in additional subsidies according to the US Department of Health and Human Services.[1] This provision of the law is set to sunset at the end of 2025. The expiration of the EPTC will likely result in a decrease in Marketplace medical plan enrollments, as some members are priced out of the Marketplace due to an increase in premiums.

Estimated Impacts

Using preliminary estimates, we decreased monthly enrollment estimates by 3,800 each month starting in January 2026 to reflect the impact of the expiration of the EPTC. The impact of OHP Bridge was expected to decrease enrollment over a significant period of time. Approximately 11,000 members are expected to move from the Marketplace to OHP Bridge in CY 2025 and an additional 7,500 during CY 2026.

Both the impact of OHP Bridge and No EPTC were applied to the baseline exponential smoothing forecast model resulting in an estimated average medical enrollment for CY 2026 of 114,061. See the graph below.

[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



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.

Federal legislation that proposes additional restrictions on premium tax credits may price individuals out of 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 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. 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 2026 would be 114,061 members. An assessment rate of $6.85 PMPM would generate $9.4 million in revenue. With the same enrollment, a $5.50 PMPM would generate $7.5 million. If the average enrollment were 10,000 a month lower than forecast, the $6.85 PMPM would generate $8.6 million; if the enrollment were 10,000 a month higher, the $6.85 PMPM would generate $10.2 million.

CY 2026 Revenue ($millions) by Assessment Rates

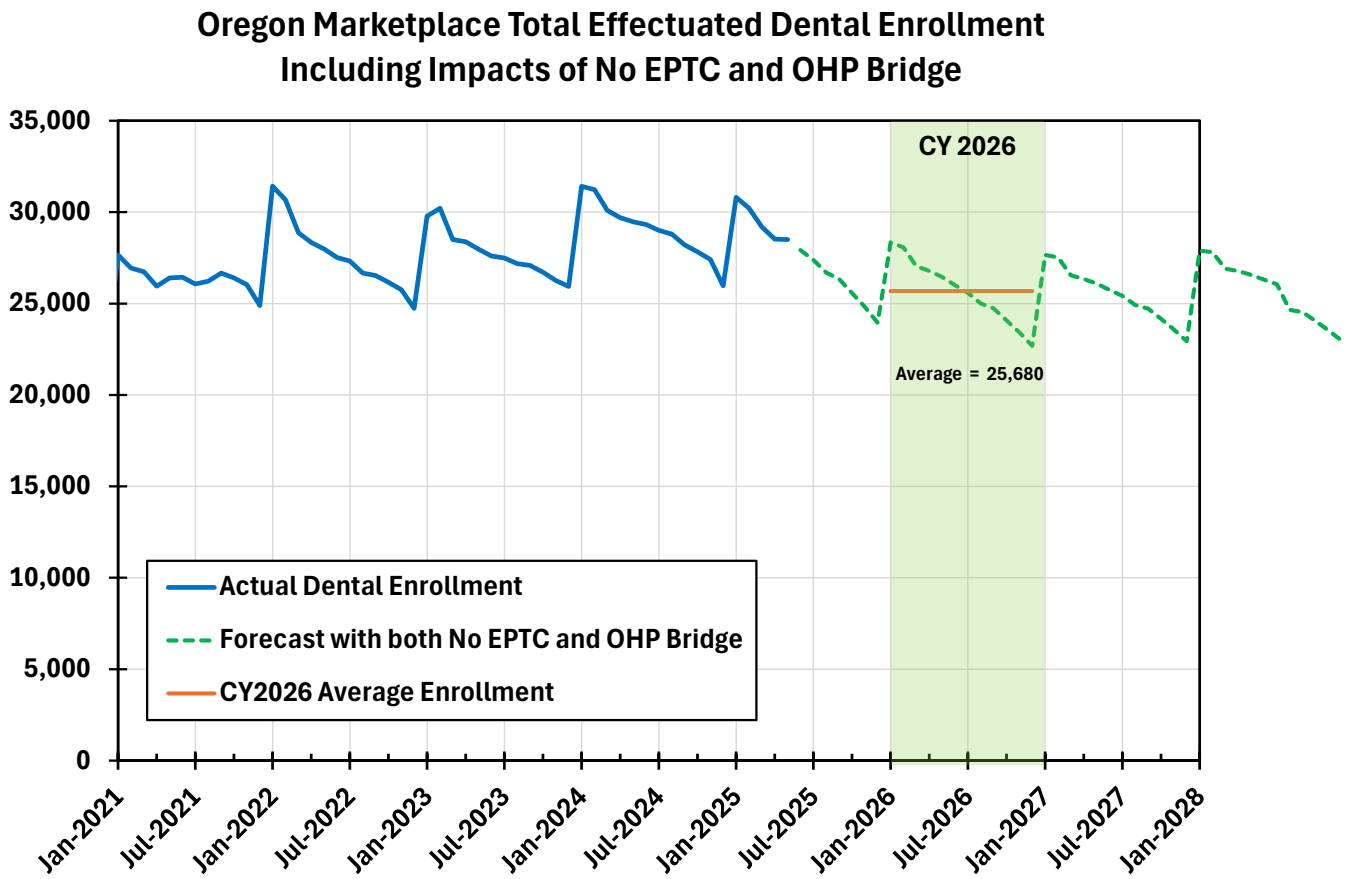
Medical Enrollment Forecast	PMPM assessment rates ($dollars)					Equlibrium Rates ($dollars)
	$7.50	$7.00	$6.85	$6.00	$5.50	
Forecast + 15,000	$11.6 mil	$10.8 mil	$10.6 mil	$9.3 mil	$8.5 mil	$6.06
Forecast + 10,000	$11.2 mil	$10.4 mil	$10.2 mil	$8.9 mil	$8.2 mil	$6.30
Forecast + 5,000	$10.7 mil	$10.0 mil	$9.8 mil	$8.6 mil	$7.9 mil	$6.56
Forecast = 114,061	$10.3 mil	$9.6 mil	$9.4 mil	$8.2 mil	$7.5 mil	$6.85
Forecast - 5,000	$9.8 mil	$9.2 mil	$9.0 mil	$7.9 mil	$7.2 mil	$7.17
Forecast - 10,000	$9.4 mil	$8.7 mil	$8.6 mil	$7.5 mil	$6.9 mil	$7.51
Forecast - 15,000	$8.9 mil	$8.3 mil	$8.1 mil	$7.1 mil	$6.5 mil	$7.89

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 2026 total expenditures are forecasted to be $10,088,285. The dental plan assessment is estimated to raise $138,674 and investment income will generate about $571,498, for a total of $710,172, so the medical plan assessment will need to generate about $9.38 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 $6.85 PMPM. If monthly enrollment were 5,000 higher, the equilibrium rate would be $6.56 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. Due to the impacts of OHP Bridge and expiration of the EPTC, we also expect a decrease in dental plan enrollment. Our forecast for stand-alone dental enrollment decreases the enrollment estimates by the same relative amount as the medical enrollment estimates.



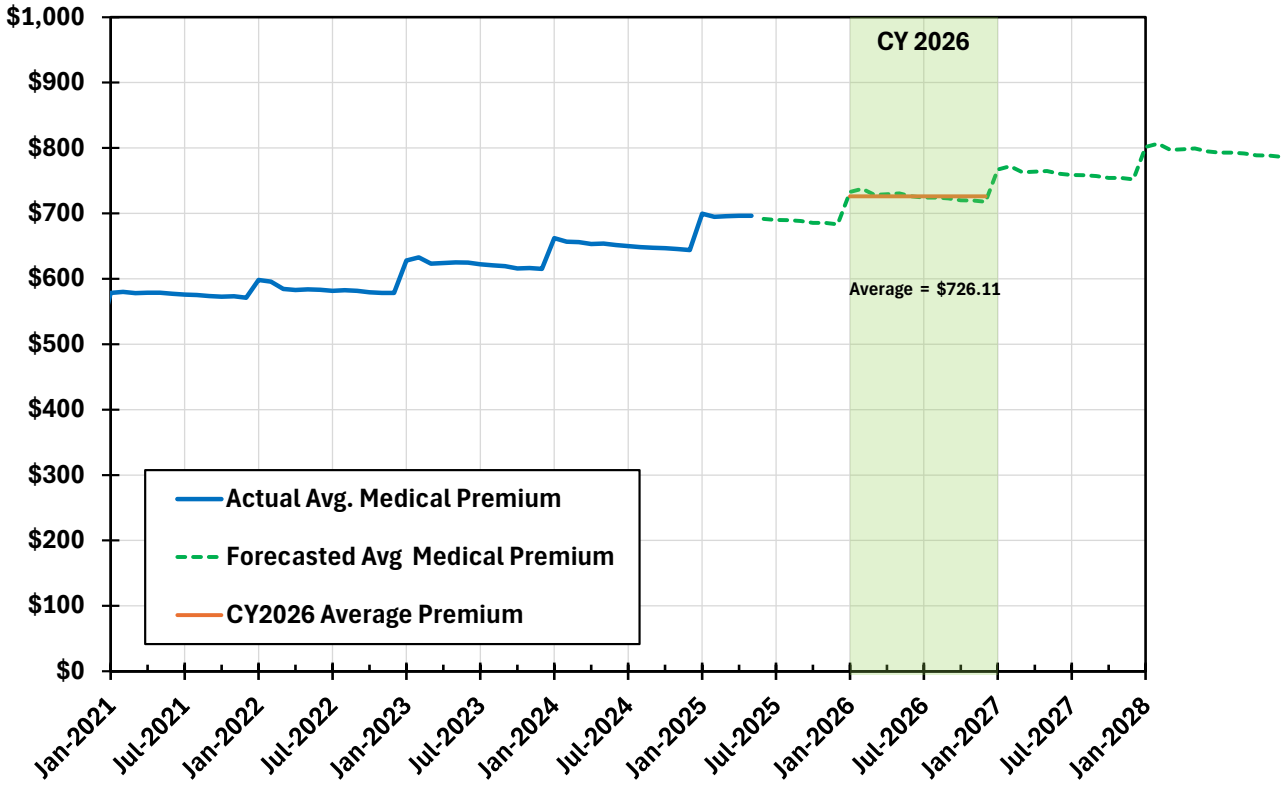
We also need to forecast medical and dental premiums to ensure that the assessments will not exceed certain limits. The medical premiums have shown significant increases in the last few years. We use the historical value for the average premium by month from January 2022 to May 2025. We have also seen the requested rates from providers for CY 2026. They are very similar to the requested rates for CY 2025 in terms on requested increases, so we should expect a similar jump in overall premiums this year as last year and that is what the forecast shows. The forecasted average premium in CY 2026 is $726.11. 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 2026 and the average premium for a stand-alone dental plan will be $38.26.

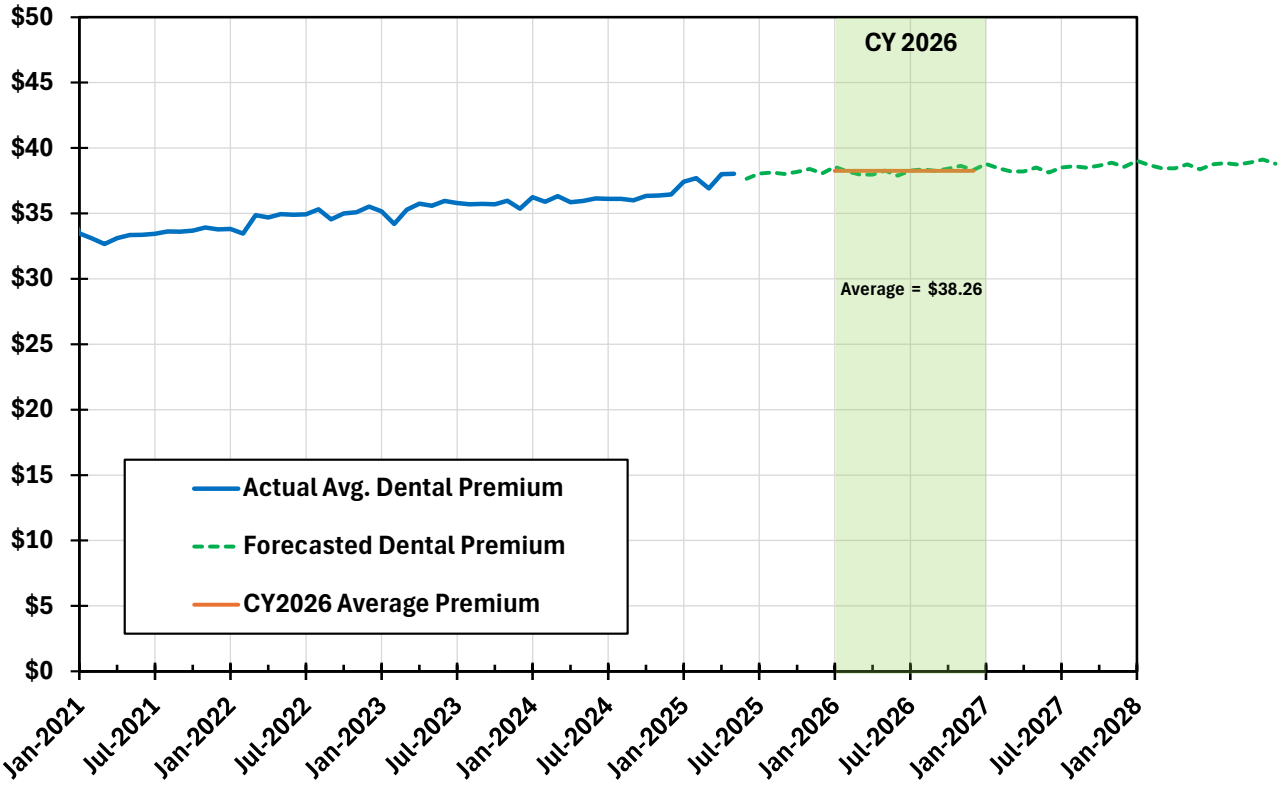
Federal exchange technology charges

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 2025, the federal technology charge was decreased to 1.2 percent of premium for State-based Marketplaces on the Federal Platform (SBM-FP). It is set to increase to 2.0 percent for CY 2026.

Oregon Marketplace Average Medical Premium



Oregon Marketplace Average Stand Alone Dental Premium



Enrollment forecast summary

The following table provides a summary by calendar year using the current assessment rates, the proposed enrollment forecast, the state provided expenditure estimates and assumed federal technology charges. The table also includes the forecast average premiums for medical and stand-alone dental policies. CY 2026 and the medical assessment are highlighted with dashed lines.

Medical Plans Summary, with Assessment Rate Assumptions

	2020	2021	2022	2023	2024	2025	2026
Average enrollment	127,715	128,217	131,135	127,100	132,049	126,139	114,061
% change	1.9%	0.4%	2.3%	-3.1%	3.9%	-4.5%	-9.6%
Total premiums ($ millions)	$818.6	$886.3	$919.3	$949.1	$1,032.1	$1,046.5	$993.8
Avg premium	$534.12	$576.02	$584.19	$622.29	$651.32	$691.38	$726.11
% change	-7.3%	7.8%	1.4%	6.5%	4.7%	6.2%	5.0%
Assessment rate	$5.50	$5.50	$5.50	$5.50	$5.50	$5.50	$6.85
Assessments ($ millions)	$8.4	$8.5	$8.7	$8.4	$8.7	$8.3	$9.4
Rate as % of avg premium	1.0%	1.0%	0.9%	0.9%	0.8%	0.8%	0.9%
Federal tech. charges ($ millions)	$20.5	$15.5	$20.7	$21.4	$18.6	$12.6	$19.9
Fed. as % of avg premium	2.50%	1.75%	2.25%	2.25%	1.80%	1.20%	2.00%

Dental Plans Summary

	2020	2021	2022	2023	2024	2025	2026
Average enrollment	23,399	26,367	27,664	27,759	29,038	27,493	25,680
% change	5.4%	12.7%	4.9%	0.3%	4.6%	-5.3%	-6.6%
Total premiums ($ millions)	$10.2	$10.6	$11.5	$11.8	$12.6	$12.5	$11.8
Avg premium	$36.28	$33.42	$34.75	$35.51	$36.15	$37.88	$38.26
% change	-7.3%	-7.9%	4.0%	2.2%	1.8%	4.8%	1.0%
Assessment rate	$0.36	$0.36	$0.36	$0.36	$0.36	$0.36	$0.45
Assessments ($ millions)	$0.101	$0.114	$0.120	$0.120	$0.125	$0.119	$0.139
Rate as % of avg premium	1.0%	1.1%	1.0%	1.0%	1.0%	1.0%	1.2%
Federal tech. charges ($ millions)	$0.255	$0.185	$0.260	$0.266	$0.227	$0.150	$0.236
Fed. as % of avg premium	2.50%	1.75%	2.25%	2.25%	1.80%	1.20%	2.00%

Medical and Dental Combined

	2020	2021	2022	2023	2024	2025	2026
Total premiums ($ millions)	$828.8	$896.8	$930.8	$960.9	$1,044.7	$1,059.0	$1,005.6
Total assessments ($ millions)	$8.53	$8.58	$8.77	$8.51	$8.84	$8.44	$9.51
Total fed. Charges ($ millions)	$20.72	$15.69	$20.94	$21.62	$18.80	$12.71	$20.11
Assessment and fed. charges ($ millions)	$29.25	$24.27	$29.72	$30.13	$27.64	$21.15	$29.63
Total % of avg premium	3.5%	2.7%	3.2%	3.1%	2.6%	2.0%	2.9%

Marketplace financial outcomes

The following table summarizes the forecast financial outcomes with the current assessment rates. The CY 2022 – CY 2024 figures are actual revenue and expenditures.

The CY 2025 – CY 2026 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 forecasted is forecasted to stay level through CY 2026.

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	$9,358,145	$10,276,684	$12,774,205
CY 2026	$10,088,285	$10,086,020	$12,771,940

An assessment rate of $6.85 was selected as the rate that will keep the fund balance constant through CY 2026. This assessment rate accounts for known impacts to revenue brought in by the Marketplace, such as decreases to enrollment due to OHP Bridge and expiration of the EPTC. Due to potential unknown impacts to the Marketplace that may result from pending federal action, an assessment rate was chosen to maintain the fund balance to allow for a reserve 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.

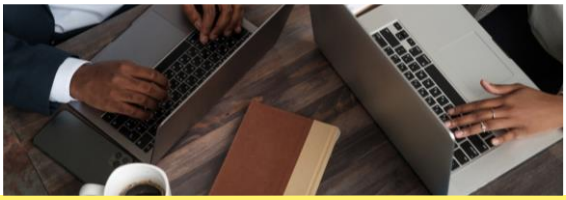
June 20, 2025

Health Insurance Marketplace Advisory Committee Meeting

1

Welcome and Roll Call

2



Meeting Guidelines

3

Meeting Protocols and Requests

- The Marketplace and the Health Insurance Marketplace Advisory Committee (HIMAC) is committed to safe and inclusive meetings for all attendees.
- We have differences in 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 it 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.

4

Meeting Protocols and Requests, Continued

- For transcribing and accessibility purposes, please make sure to state your name before posing your question or comment during a presentation.
- We ask any members of the public to hold questions or comments until our Public Comment sessions. There will be one in the middle and at the end of the meeting.
- If you are subject of unacceptable behavior or have witnessed any such behavior during this meeting, please connect with:

  Chiqui Flowers, Marketplace Director
  chiqui.l.flowers@oha.oregon.gov
  503-884-6017

5

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

6

Approval of April 17, 2025 Meeting Minutes

7

Marketplace Assessment Overview

Victor Garcia
Marketplace Operations Advisor
and Program Liaison

8

8

What is the Marketplace Assessment?

The Marketplace is funded by an assessment on insurance companies offering qualified health plans (QHP) through the Marketplace

Assessment rate is set by Oregon Administrative Rule (OAR) amendment process annually

Insurers currently pay a separate assessment to the Marketplace and the federal Marketplace (HealthCare.gov)

9

Setting Assessment Rates

The Marketplace has maintained a per-member per-month (PMPM) structure

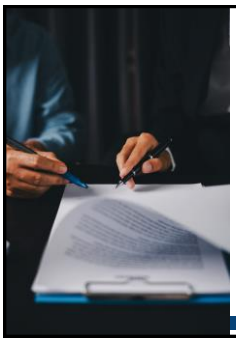
- HealthCare.gov and most other states assess insurers based on a percentage of premiums of QHP enrollees
- Oregon's method generally tracks much closer to anticipated Marketplace expenses and does not rise at the same rate as medical cost inflation like insurance premiums do

There are separate rates for medical and stand-alone dental carriers

- These rates are reviewed annually, adjusted based on budget and enrollment projections, and updated by amending OAR 945-030-0030

Marketplace statutes require that the rates be reviewed by HIMAC before filing the assessment rule

10



Proposed 2026 Marketplace Assessment Analysis

Caleb Lavan
Senior Manager
CBIZ Optumas

11

Overview

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

CBIZ Optumas

6/20/2025 12

12

Assessment Rate History

Assessment rates have been unchanged for the past 6 years

Marketplace Assessment Rates

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

13

Main Points (Spoilers!)

- We recommend an increase in the Medical Assessment rate to $6.85 and the Dental Assessment rate to $0.45.
- The rate needs to go up because enrollment is forecasted to go down and expenses are projected to increase.
- There are reserves, but we do not recommend spending those down in 2026 during this uncertain environment.
- Keeping reserves will mitigate risk and provide additional investment income.

14

Expenditures

Marketplace Expenditures, Historical and Projected

CY 2022-2024 actuals and CY 2025-2026 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	$7,984,016	$1,374,129	$9,358,145
CY 2026	$8,549,394	$1,538,891	$10,088,285

SAEC - OHA Shared Assesment and Enterprise-wide Costs

15

Forecasting Effectuated Medical Plan Enrollment

- Create a Baseline Forecast using recent history
- Add impacts for known factors that will impact enrollment
  - The end of the Enhanced Premium Tax Credits ("No EPTC")
  - The impact of the OHP Bridge
- Note that impacts due to the 2025 Marketplace Program Integrity and Affordability Proposed Rule and the federal budget reconciliation packages are not included in the forecast.

16

Not Included in the Forecast: Other Potential Risks

- End of automatic re-enrollment
- End of provisional eligibility for advanced premium tax credits
- Federal action on Medicaid
- Shorter open enrollment period
- Overall market uncertainty and volatility
- Other federal administrative choices
- Economic downturn

17

Impacts of the End of Enhanced Premium Tax Credits

- Reduces Premium Tax Credits (substantially in some cases).
- Goes into effect on January 1, 2026.
- Initial analysis estimates a **decrease of around 4,000** in enrollment.
- There is evidence consumers are relatively inelastic to price and we do not anticipate large shifts in consumer behavior.

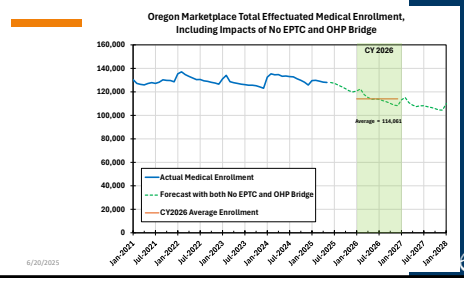
18

Impacts of the OHP Bridge on Marketplace Enrollment

- Makes those with incomes 138% - 200% FPL eligible for OHP Bridge.
- Assumes additional people have already started moving as early as July 2024.
- Assume everyone eligible for the OHP Bridge currently on Marketplace plans are not forced to transition all at once.
- Preliminary analysis estimates at least an **11,000 decrease** in enrollments in 2025.
- Estimate an **additional 7,500 decrease** in 2026.

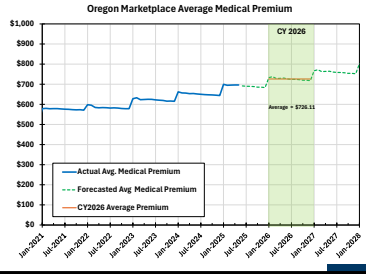
19

Medical Plan Enrollment



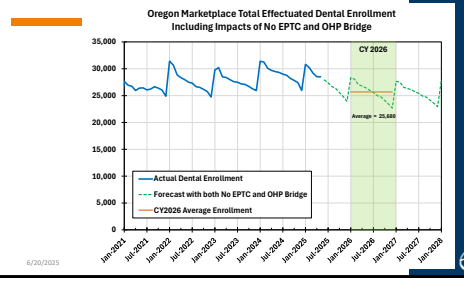
20

Average Medical Premiums



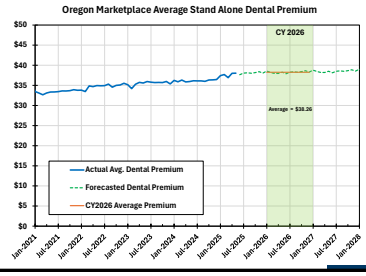
21

Stand-Alone Dental Enrollment



22

Dental Premiums



23

Revenue Required from Medical Assessments

- Total Expenditures for CY 2026 $10.1 Million
- $139k Dental Assessment Revenue with $0.45 assessment
- $573k Investment Income with steady fund balance
- Required Revenue from Medical Assessments is $9.4 Million

24

Sensitivity of Forecast Model

CY 2026 Revenue ($millions) by Assessment Rates

Medical Enrollment Forecast	PMPM assessment rates ($dollars)					Equilibrium Rates ($dollars)
	$7.50	$7.00	$6.85	$6.00	$5.50	
Forecast + 15,000	$11.6 mil	$10.8 mil	$10.6 mil	$9.3 mil	$8.5 mil	$6.06
Forecast + 10,000	$11.2 mil	$10.4 mil	$10.2 mil	$8.9 mil	$8.2 mil	$6.30
Forecast + 5,000	$10.7 mil	$10.0 mil	$9.8 mil	$8.6 mil	$7.9 mil	$6.56
Forecast = 114,061	$10.3 mil	$9.6 mil	$9.4 mil	$8.2 mil	$7.5 mil	$6.85
Forecast - 5,000	$9.8 mil	$9.2 mil	$9.0 mil	$7.9 mil	$7.2 mil	$7.17
Forecast - 10,000	$9.4 mil	$8.7 mil	$8.6 mil	$7.5 mil	$6.9 mil	$7.51
Forecast - 15,000	$8.9 mil	$8.3 mil	$8.1 mil	$7.1 mil	$6.5 mil	$7.89

25

Federal Exchange Technology Charges

- Federal Exchange technology charges are separate from the assessment and are paid directly to the federal government.
- It was adjusted down to 1.2 percent on April 15, 2024 for CY 2025 and will be adjusted upward on Jan. 15, 2025 to be at 2.0 percent in CY 2026 if EPTCs are not extended and 1.8% if EPTCs are extended.
- The current state assessment of $5.50 PMPM is roughly 0.80 percent of the average premium for 2025. At $6.85, the state assessment represents about 0.94 percent of the average premium proposed for 2026.

26

Summary

Medical Plans Summary, with Assessment Rate Assumptions

	2020	2021	2022	2023	2024	2025	2026
Average enrollment	127,745	126,157	131,125	127,190	122,668	136,108	114,061
% change	1.9%	0.4%	2.3%	-3.1%	3.9%	-6.3%	-9.8%
Total premiums ($ millions)	$818.6	$886.3	$918.3	$949.1	$1,032.1	$1,046.5	$993.8
Avg premium	$534.12	$576.02	$584.99	$622.29	$651.32	$691.36	$736.11
% change	-7.3%	7.8%	1.4%	6.5%	4.7%	6.2%	5.6%
Assessment rate	$5.50	$5.50	$5.50	$5.50	$5.50	$5.50	$6.85
Assessments ($ millions)	$6.4	$6.5	$6.7	$6.4	$6.7	$6.5	$6.4
Rate as % of avg premium	1.0%	1.0%	0.9%	0.9%	0.8%	0.8%	0.9%
Federal tech. charges ($ millions)	$20.5	$15.5	$20.7	$21.4	$18.6	$12.6	$19.9
Fed. as % of avg premium	2.58%	1.75%	2.25%	2.25%	1.80%	1.20%	2.69%

Dental Plans Summary

	2020	2021	2022	2023	2024	2025	2026
Average enrollment	23,399	26,367	27,664	27,759	29,038	27,693	25,680
% change	3.4%	12.7%	4.9%	0.3%	4.6%	-4.5%	-4.6%
Total premiums ($ millions)	$10.2	$10.6	$11.5	$11.8	$12.6	$12.5	$11.8
Avg premium	$36.28	$33.42	$34.75	$35.51	$36.15	$37.88	$38.26
% change	-7.3%	-7.9%	4.0%	2.2%	1.8%	4.8%	1.0%
Assessment rate	$0.36	$0.36	$0.36	$0.36	$0.36	$0.36	$0.45
Assessments ($ millions)	$0.101	$0.114	$0.120	$0.120	$0.125	$0.119	$0.120
Rate as % of avg premium	1.0%	1.1%	1.0%	1.0%	1.0%	1.0%	1.2%
Federal tech. charges ($ millions)	$0.255	$0.185	$0.260	$0.266	$0.227	$0.150	$0.236
Fed. as % of avg premium	2.50%	1.75%	2.25%	2.25%	1.80%	1.20%	2.69%

Medical and Dental Combined

	2020	2021	2022	2023	2024	2025	2026
Total premiums ($ millions)	$828.8	$896.8	$929.9	$960.9	$1,044.7	$1,059.0	$1,005.6
Total assessments ($ millions)	$6.53	$6.58	$6.77	$6.51	$6.84	$6.46	$6.51
Total fed. Charges ($ millions)	$20.72	$15.69	$20.94	$21.62	$18.80	$12.71	$20.11
Assessment and fed. charges ($ millions)	$29.25	$24.27	$29.72	$30.13	$27.64	$21.15	$29.63
Total % of avg premium	3.5%	2.7%	3.2%	3.1%	2.6%	2.0%	2.9%

27

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	$9,358,145	$10,276,684	$12,774,205
CY 2026	$10,088,285	$10,086,020	$12,771,940

28

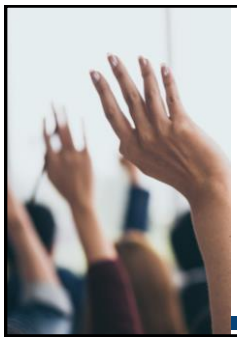
Questions?

- Caleb Lavan, Senior Manager, Myers & Stauffer
  clavan@mslc.com
  (503) 998-1945

29

Public Comment

30



Next Steps and Voting

Victor Garcia

Marketplace Operations Advisor and Program Liaison

31

Wrap Up

Next meeting:
July 17, 2025

32

Thank You

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Dawn Shaw at Dawn.A.Shaw@oha.oregon.gov or 503-951-3947 (voice/text). We accept all relay calls.

Health Policy and Analytics Division
Oregon Health Insurance Marketplace
500 Summer Street E-56
Salem, OR 97301
855-268-3767
OregonHealthCare.gov | CuidadoDeSalud.Oregon.gov

OREGON HEALTH AUTHORITY

OREGON HEALTHCARE.gov

33

33