



Oregon 1332 State Innovation Waiver Five-Year Extension Application State Reinsurance Program

Revised and updated July 1, 2022



Department of Consumer and Business
Services 350 Winter St. NE
Salem, OR 97309
503-302-4795

<https://dfr.oregon.gov/business/reg/health/pages/oregon-reinsurance-program.aspx>



Oregon

Kate Brown, Governor

Department of Consumer and Business Services

Director's Office

350 Winter Street NE, Room 200

PO Box 14480

Salem, OR 97309-0405

Voice: 503-947-7872

Fax: 503-947-0088

www.dcbs.oregon.gov

The Honorable Janet Yellen
Secretary of the Treasury

The Honorable Xavier Becerra
Secretary of Health and Human Services

Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, D.C. 20220

Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

April 22, 2022

Dear Secretaries Yellen and Becerra,

The state of Oregon is pleased to submit this revised and updated application for a five-year extension of Oregon's Section 1332 State Innovation and Empower Waiver to continue Oregon's reinsurance program for 2023-27. The state requests that the U.S. Department of Treasury and the U.S. Department of Health and Human Services approve Oregon's application for a 1332 waiver extension.

Currently, Section 1312(c)(1) of the Affordable Care Act (ACA) is waived through 2022 to allow the state to implement a reinsurance program funded by federal pass-through savings and state funding. We are requesting that Section 1312(c)(1) be waived for an additional five years, for the period of 2023-27, in order for Oregon to continue implementing the reinsurance program for this period.

The Oregon Reinsurance Program (ORP) has been successful during our current waiver period (2018-22). The ORP reduced premiums more than 8.2 percent on average statewide for Oregonians who purchased insurance on the individual market. Further, the American Rescue Plan and extended open enrollment period was instrumental in increasing enrollment throughout the state. Access to health care is vital for all Oregonians and our health care market has been stable during the reinsurance program period. The impact of the COVID-19 pandemic reinforces the need to continue the ORP in order to ensure stability, affordability, access, and comprehensive health plans on the health care marketplace.

Thank you for considering our application and supporting Oregon's health care goals for high-quality care at affordable prices. We are happy to provide any additional supplemental materials that would be helpful for the respective departments to complete their review.

Sincerely,

Andrew R. Stolfi
Oregon Insurance Commission

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Section 1: Extension Request and Reinsurance Program Overview

Oregon's waiver request

The state of Oregon, through its Department of Consumer and Business Services (DCBS), submits this 1332 State Innovation Waiver Extension request to the U.S. Department of Health and Human Services (HHS), the U.S. Department of Treasury, and the Centers for Medicare and Medicaid Services (CMS). This request seeks to extend the waiver of Section 1312(c)(1) under Section 1332 of the Affordable Care Act (ACA) for five additional years, from Jan. 1, 2023, through Dec. 31, 2027.

This waiver will affect no other provision of the ACA, but will continue to follow the guardrails set by Section 1332, and principles established by CMS. No other changes are being proposed to Oregon's existing 1332 waiver, except for the five-year waiver extension. The Oregon waiver continues to stabilize the individual health insurance marketplace, drive enrollment, spur insurer participation, and lower market wide index rates, lowering premiums and reducing federal payment of advance premium tax credits (APTC). Next, the waiver extension will continue to act under specific terms and conditions set forth by CMS.

Oregon Reinsurance Program overview

Oregon HB 2391 (2017), which established the Oregon Reinsurance Program (ORP) under administration by DCBS, was signed into law on July 5, 2017. This bipartisan legislation authorized DCBS to apply for a Section 1332 waiver from CMS to implement the ORP for seven years from Jan. 1, 2018, through Dec. 31, 2024. The ORP was funded through a 1.5 percent premium assessment levied on major medical premium policies issued in this state. Beginning in 2018, HB 2391 was implemented by the ORP to reimburse eligible insurers for certain high-cost health care claims.

HB 2391 was amended by HB 2010 (2019)¹ on March 25, 2019, and authorized the ORP to operate through Dec. 31, 2027, to coincide with the 10-year Oregon State PPACA 1332 Innovation and Empowerment Waiver. The bill also raised the premium assessment levied on major medical and stop-loss policies from 1.5 percent to 2.0 percent. Through this waiver extension request, Oregon seeks federal pass-through funds — provided via net premium tax credit savings, estimated to be over \$54 million per year through 2027 — to partially recoup state expenditures. ORP retains a small portion of the assessments, most of the assessment goes toward funding the Medicaid expansion (Assessments are passed on through premiums).

The ORP will reimburse individual health insurers for a proportion (co-insurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2022, Oregon has set the reinsurance cap at \$1 million, the co-insurance rate at 50 percent, and the attachment point at an amount so the total estimated reinsurance payments match the funding available. If the 2023-27 experience is worse than expected and the funding is not sufficient, DCBS will reduce the co-insurance rate and decrease reinsurance payments. If the 2023-27 experience is better than expected, Oregon will retain the funds in reserve for future payouts.

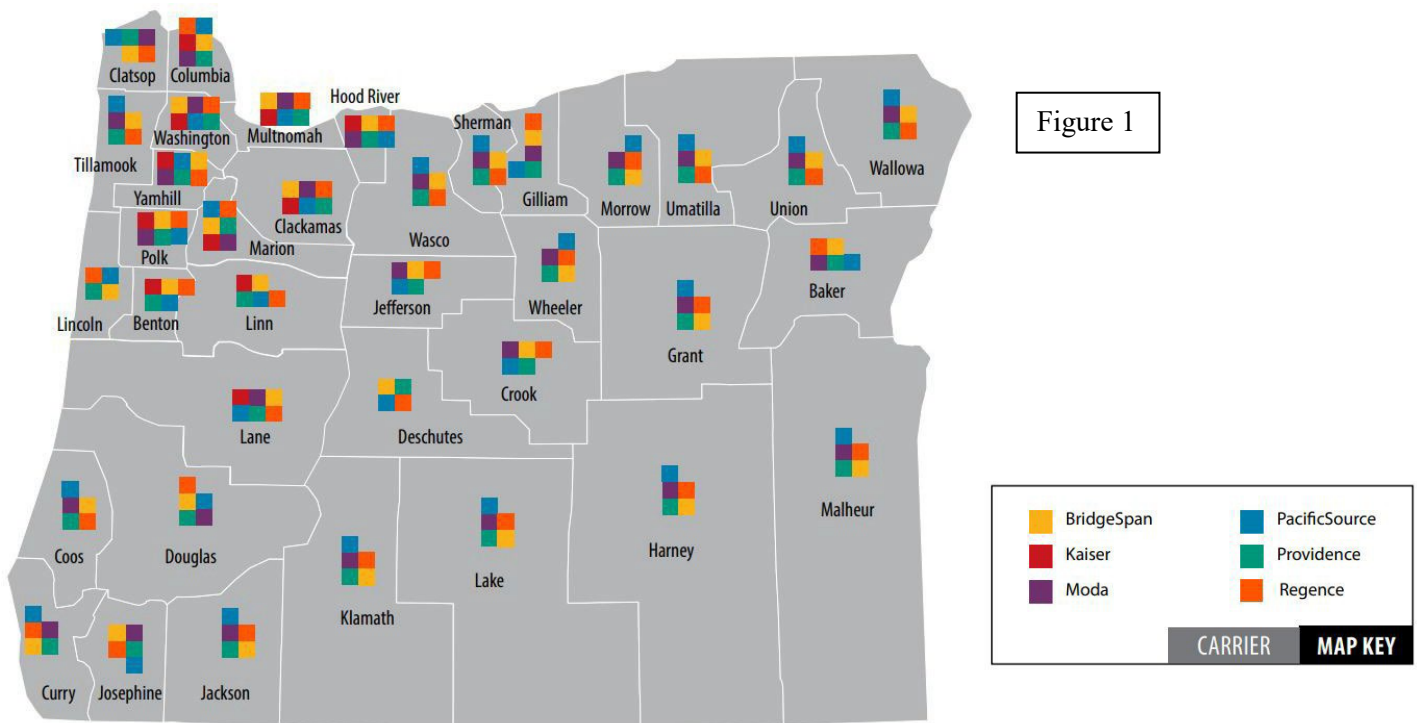
¹ Oregon Laws Chapter 2 §1-20 (2019) https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2019orLaw0002.pdf

Oregon Reinsurance Program design

The Oregon Reinsurance Program will continue to operate like a traditional reinsurance program by reimbursing individual health insurers for a percentage (the co-insurance rate) of an enrollee’s claims between an attachment point and a cap. DCBS will set the program parameters (co-insurance rate, attachment point, and cap) annually through administrative rule. The goals of the program are to lower premiums, incentivize enrollment, and encourage carrier participation. Progress of the ORP has been monitored by CMS over the past five years based on annual and quarterly reporting.² Approximately 177,739 Oregonian saw their premiums decrease in 2022 as a result of reinsurance.³

The ORP issues reinsurance reimbursement payments (Table 1a) on an annual basis, in the fall of the year following the applicable benefit year under Oregon Administrative Rule 836-150-0040 (Appendix 2). Once carriers submit their claims, DCBS audits all claims submissions. Once the audits have been completed, the ORP will notify eligible insurers of the reimbursement amounts they are owed and allow for a 30-day appeals process before making final payments. Payments are made electronically and by certified mail.

Years	2018	2019	2020	2021	2022
Enrollment	191,556	177,201	174,746	167,215	177,739
Attachment Point	\$95,000 to 1,000,000	\$90,000 to 1,000,000	\$90,000 to \$1,000,000	\$83,000 to 1,000,000	\$92,000 to 1,000,000
Coinsurance	59.2%	50%	50%	50%	50%
Reimbursements	\$90,000,000	\$87,286,034.24	\$97,090,164.11	Est. \$107,800,000	Est. \$107,700,000



² Oregon Health Insurance enrollment report 2018-2021 [Division of Financial Regulation : Health insurance enrollment : Annual health insurance report : State of Oregon](https://dfp.oregon.gov/DivisionofFinancialRegulation/HealthInsuranceEnrollment/AnnualHealthInsuranceReport/StateofOregon)

³ Final Rate for 2022 health plans <https://dfp.oregon.gov/healthrates/Pages/approved-2022-plan-rates.aspx>

Issuer Participation and Plan Offerings

Six health carriers offer plans on the Oregon Health Insurance Marketplace from which consumers can choose (Table 1b). The state is divided into seven geographic areas across 36 counties, with at least four health care carriers offering plans in each zone (Figure 1).

Table 1b shows the number of participating carriers by year, as well as the number of plan offerings and the number of Silver plan offerings (excluding CSR Variant plans) on-exchange, off-exchange, and in total. As can be seen in this table, the number of issuers participating in the Oregon ACA market has been stable. Additionally, the number of plans available for Oregonians has increased in each zone during the waiver period (Appendix 6). Further, individual plan coverage has grown in each county from a minimum for two plans per county in 2018 to four individual plans as of 2022.

Table 1b Issuers and Plan Offerings										Minimum# of Plan coverage Per County**
	Total			On-Exchange			Off-Exchange Only			
	Issuers*	Plans	Silver Plan	Issuers	Plans	Silver Plan	Issuers	Plans	Silver Plan	
2019	7	67	25	5	52	17	2	15	8	2
2020	7	86	31	5	66	21	2	20	10	3
2021	6	92	31	6	90	29	0	2	2	3
2022	6	112	53	6	82	27	0	30	26	4

*In 2021, one carrier representing 1% of the 2020 individual market, voluntarily left the market.

** [Division of Financial Regulation : Final Rates for 2022 health plans : Oregon health rates : State of Oregon](#)

The ORP has proven to be a vital resource for these past five years, especially due to emerging health issues like COVID-19. The ORP has operated consistent with the statutory guardrails of comprehensiveness, affordability, coverage, and federal deficit neutrality. With the waiver and the ORP, Oregon has been able to offer a robust essential health benefits package on the Oregon individual health insurance marketplace. Further, the American Rescue Plan Act (ARPA) and Special Enrollment Period (SEP) proved to accomplish the goal for which it was designed, to provide at risk Oregonians — in the midst of a pandemic — access to health care. As a result of the ARPA, approximately 84 percent more Oregonians enrolled in health coverage during the 2021 SEP⁴ vs. 2020 enrollment period.

Health Equity

Oregon’s reinsurance program was designed to stabilize the individual market premium rates for consumers by reinsuring certain high cost claims that contribute to rate increases (Oregon’s reinsurance program is based on expense rather than medical condition). The reinsurance program was started when the division saw insurers exit rural Oregon markets, leaving consumers in those areas with limited plan options and increasing rates. Since implementing the reinsurance program rates have stabilized and consumers across Oregon have at least two insurer options in every county. The reinsurance program is one of the many ways we have expanded our diversity, equity and inclusion (DEI) work in Oregon.

Here are some of the things that we are working on around DEI that specifically intersect with the health benefit plan markets:

- Monthly industry DEI questions at Industry Communication meetings. These questions

target real-time DEI issues that come into our office through consumer outreach or legislative inquiry. This started in January 2022 and we've covered topics including:

- Contracting challenges with Indian Health Services (IHS) Providers.
- Gender information on health insurance applications – and understanding the barriers experienced to having more gender options in health insurance applications.
- Gender affirming care challenges.
- Agent/Producers representation in DEI markets.
- Barriers to collecting race, ethnicity, etc. information from consumers and providers.

The division's 2021 market conduct exam on reproductive health benefits identified that insurers were continuing to use non-permissible limitations on certain benefits, specifically limitations related to age and gender. The exam is still in process, however insurers will need to update practices to remove these limitations as they move to compliance in this area.

Oregon does not anticipate any negative DEI impacts as a result of the waiver extension. The effect of the waiver is to lower premiums for all consumers without financial assistance.

Section 2: Economic Analysis 2023-27

In its first five years, the ORP successfully fulfilled the goals outlined in the guardrails (STC, 2017).⁵ According to actuarial analysis (Appendix 6), ORP reduced premiums (Table 2) on average statewide for Oregonians who purchased insurance on the individual market and exceeded the premium reduction goals in Oregon Law Chapter 2 §18-26 (2019) and Oregon's Section 1332 Waiver.

2018	2019	2020	2021	2022
7.5%	8.3%	8.0%	8.8%	8.8%

⁴American Rescue Plan Makes health coverage accessible, <https://www.oregon.gov/newsroom/pages/NewsDetail.aspx?newsid=64386>

⁵PPACA 1332 Waiver Standard Terms and Conditions <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Approval-Letter-OR.pdf>

As shown in Table 3, actuarial analysis for the waiver extension period estimates that the reinsurance program will reduce premiums by approximately 8.3 percent in 2023. Approval of Oregon’s waiver extension will allow the state to continue providing Oregonians with high quality health care at affordable prices. Actuarial analyses are conducted annually to coincide with current enrollment and approved premium rates on the individual health insurance market.

Table 3: 2023 Premium Reduction and Impact Estimate

Description	PMPM
2023 Premium per member per month (PMPM) without the program	\$659.18
2023 Premium per member per month (PMPM) with the program	\$604.25
Reduction	-\$54.93
Approx. Premium Impact % (-\$54.93 ÷ \$659.18)	-8.3%

To continue administration of the state’s reinsurance program, Oregon seeks federal pass-through funds in the amount the federal government would have otherwise paid in APTC absent consideration of the reinsurance payments in the market wide index rate. By mitigating high-cost individual health insurance claims, the ORP will continue to stabilize Oregon’s individual market and make premiums more affordable. With the waiver and reinsurance program, Oregon anticipates that individual premiums, including premiums for the second lowest cost Silver plan, will be lower, net of the premium assessment, by an approximately 8.0 percent from 2023 through 2027, than they would have been without the waiver and reinsurance program.⁶

The ORP and federal pass-through funding

The ORP is designed to improve Oregonians’ access to affordable and comprehensive coverage. The goals of the reinsurance program are to spread the risk of high-cost claimants across the broader health insurance market, thereby lowering premiums for the individual market. In doing so, the reinsurance program should incentivize individual enrollees to join or remain in the market, encourage insurer participation, and reduce overall instability. In addition to providing lower premiums to Oregonians, the reinsurance program will also reduce federal expenditures through lower APTC.

In order to secure the required state funding, Oregon will continue a premium assessment levied on major medical premiums for policies issued in this state. Because the amount of APTC available for eligible consumers is tied to the second lowest cost Silver plan (SLCSP) available through the Oregon Health Insurance Marketplace (OHIM), the amount the federal government will be required to pay in APTC will be reduced. The ORP seeks to recoup federal savings from these reduced APTC payments (Table 4), net of other costs that result from the PPACA 1332 State Innovation and Empowerment Waiver. Oregon seeks these funds to offset some costs associated with the reinsurance program. Table 4a (With Waiver) and Table 4b (Without Waiver) demonstrates Oregon’s projected membership enrollment for the next five years.

⁶ The final approved 2022 rates were determined independently and reflect all new taxes, including those not applicable to the ORP. The results of the 1332 waiver analysis are consistent with the results of rate review through July 30, 2021.

Table 4
Deficit Neutrality Projection, 2023-2027

<u>Without Waiver</u>	2023	2024	2025	2026	2027
Avg State 2LCSP	\$588	\$623	\$651	\$680	\$711
APTC Agg Prem	\$714,811,458	\$757,700,146	\$791,038,952	\$826,635,705	\$863,834,311
APTC Max Prem Paid	\$208,559,161	\$213,601,206	\$218,765,146	\$224,053,927	\$229,470,568
Total APTC	\$506,252,297	\$544,098,939	\$572,273,806	\$602,581,777	\$634,363,743
Total PTC	\$480,939,682	\$516,893,992	\$543,660,115	\$572,452,689	\$602,645,556
<u>With Waiver</u>					
Avg State 2LCSP	\$540	\$572	\$597	\$624	\$652
APTC Aggr. Prem	\$655,916,516	\$695,271,507	\$725,863,453	\$758,527,309	\$792,661,038
APTC Max Prem Paid	\$208,559,161	\$213,601,206	\$218,765,146	\$224,053,927	\$229,470,568
Total APTC	\$447,357,355	\$481,670,301	\$507,098,307	\$534,473,381	\$563,190,470
Total PTC	\$424,989,487	\$457,586,786	\$481,743,392	\$507,749,712	\$535,030,946
PTC Savings	\$55,950,195	\$59,307,207	\$61,916,724	\$64,702,976	\$67,614,610
Exchange fee decrease	\$1,216,357	\$1,292,420	\$1,351,783	\$1,415,368	\$1,482,014
Net Federal Funding	\$54,733,838	\$58,014,787	\$60,564,941	\$63,287,608	\$66,132,596
Oregon Funding	\$58,566,134	\$62,083,184	\$64,817,341	\$67,736,876	\$70,787,989
Total Reinsurance	\$113,299,972	\$120,097,971	\$125,382,281	\$131,024,484	\$136,920,586
Approx. Savings	8.2%	8.2%	8.2%	8.2%	8.2%

Table 4a

Membership With Waiver	2023	2024	2025	2026	2027
100% CSR	985	985	985	985	985
94% CSR (138% to 150% FPL)	9,422	9,422	9,422	9,422	9,422
87% CSR (150% to 200% FPL)	17,671	17,671	17,671	17,671	17,671
73% CSR (200% to 250% FPL)	10,288	10,288	10,288	10,288	10,288
APTC Non-CSR (250% to 400% FPL)	46,387	46,387	46,387	46,387	46,387
Total APTC	84,753	84,753	84,753	84,753	84,753
Total Non-APTC	49,123	46,370	44,456	42,574	40,767
Total On-Exchange	133,876	131,123	129,209	127,327	125,520
Off Exchange	40,146	39,369	38,818	38,265	37,719
Total ACA	174,023	170,492	168,027	165,592	163,239

Table 4b					
Membership Without Waiver	2023	2024	2025	2026	2027
100% CSR	985	985	985	985	985
94% CSR (138% to 150% FPL)	9,422	9,422	9,422	9,422	9,422
87% CSR (150% to 200% FPL)	17,671	17,671	17,671	17,671	17,671
73% CSR (200% to 250% FPL)	10,288	10,288	10,288	10,288	10,288
APTC Non-CSR (250% to 400% FPL)	46,387	46,387	46,387	46,387	46,387
Total APTC	84,753	84,753	84,753	84,753	84,753
Total Non-APTC	44,515	42,002	40,255	38,539	36,891
Total On-Exchange	129,268	126,755	125,008	123,292	121,644
Off Exchange	38,859	38,137	37,615	37,086	36,559
Total ACA	168,128	164,891	162,624	160,378	158,203

Section 3: Evaluation of Guardrails

Table 5: Section 1332 Guardrails	
Guardrails	Effects of Waiver
Comprehensive Coverage	No change in EHBs
Affordability	Statewide average premium decrease of 8.2%
Scope of Coverage	The lower cost of coverage will allow more Oregonians to purchase or maintain coverage in the individual market than without the waiver.
Federal Deficit Neutrality	Estimated savings of \$309,491,712 over 5 years

Comprehensive coverage requirement (1332(b)(1)(A))

Waiver of Section 1312(c)(1) will not impact the comprehensiveness of coverage in the Oregon insurance market. Further, all Oregon ACA-compliant plans will be required to provide coverage of essential health benefits. Similarly, the scope of benefits provided by other types of coverage such as Medicaid, CHIP, and grandfathered plans will not be impacted.

Affordability requirement (1332(b)(1)(B))

As stated in Section I, waiver of Section 1312(c)(1) will make the cost of individual coverage lower each year than it would be without the waiver. The waiver will not affect cost sharing or the affordability of minimum essential coverage obtained through other means, such as Medicaid, CHIP, employer-based insurance, or other types of coverage, and the same number of people will have access to such coverage as they would without the waiver.⁷ Although employer health plans will have a premium assessment to fund the ORP, employer contributions and employee wages are not expected to be affected by the waiver. The waiver will have a positive effect on vulnerable people who buy coverage in the individual market since premiums will be lower. Based on these estimates, Oregonians will continue to benefit from our 1332 waiver for the next five years.

⁷Premium Rates plans for 2022 individual health insurance in 2022
<https://dfr.oregon.gov/healthrates/Documents/2022-final-rate-examples.pdf>

Scope of coverage requirement (1332(b)(1)(C))

As previously noted, waiver of Section 1312(c)(1), together with the ORP, will reduce the cost of coverage in the individual market. In each year of the waiver, the lower cost of coverage will allow more Oregonians to purchase or maintain coverage in the individual market than without the waiver. Those who obtain minimum essential coverage through other means, such as Medicaid, CHIP, employer-based insurance, or other types of coverage, will have the same access to coverage as they would without the waiver. The waiver will have a positive effect on vulnerable people who buy coverage in the individual market since premiums will be lower. All Oregon ACA-compliant plans have continued to be required to provide coverage of essential health benefits, which have not changed under the waiver.

Federal deficit requirement (1332(b)(1)(D))

As stated above, with the waiver, ARP, and Oregon's reinsurance program, Oregon anticipates that individual premiums, including premiums for the SLCSPP, will be lower, net of the premium assessment. Actuarial analysis project premiums rates will continue to remain more deficit neutral than they would have been without the waiver and reinsurance program. Because APTC are tied to the SLCSPP, with these lower premiums, the federal government will pay less in APTC. As Table 4 above demonstrates, both state and federal government will save more than \$626 million over this coming five-year budget cycle (2023-2027).

Section 4: Authority Under State Law

Regulatory oversight

Oregon HB 2391 (2017) was signed into law on July 5, 2017, establishing the Oregon Reinsurance Program to be administered by DCBS. This bipartisan legislation authorized DCBS to apply for a PPACA Section 1332 waiver from CMS to implement the ORP for seven years from Jan. 1, 2018 through Dec. 31, 2024.

On March 15, 2019, Oregon HB 2010 (2019) was signed into law by Oregon Gov. Kate Brown, amending HB 2391 by extending the ORP through Dec. 31, 2027, to coincide with an extension of Oregon's Section 1332 waiver up to 10 years. HB 2010 also increased the premium assessment from 1.5 percent to 2.0 percent on all major medical and stop-loss plans. The governor of Oregon has pledged to support the Oregon Reinsurance Program for as long as the PPACA 1332 State Innovation and Empowerment Waiver exists.⁸

Payment parameters rules (Jan. 1, 2018, Jan. 1, 2019, Jan. 1, 2020, Jan. 1, 2021, Jan. 1 2022). DCBS publishes the reinsurance payment parameters (Appendix 2) by March 30 every year. The ORP meets with stakeholders from the insurance industry to discuss the results from our contracted actuarial firm, NovaRest, on projected payment parameters based upon the data analysis. Once parameters are established in accordance with data and actuarial credibility the division conducts a public hearing to announce the parameters for the upcoming program year.

⁷ Gov. Kate Brown Letter of Support Appendix 3 public comments

Oregon Secretary of State financial audits

On April 7, 2021, Oregon Secretary of State (SOS) Audits Division concluded the financial audit of the ORP. The findings resulted in no actions taken or follow-ups needed. The SOS suggested communication be added to all lead managers, and attach screen shots of suspension and disbarment checks to insurer invoices (Appendix 7).

DCBS financial audit

On Oct. 20, 2021, Oregon Secretary of State Audits Division (Appendix 7) conducted a financial audit of DCBS. The ORP was asked to present all financial documents for the processing of reimbursements of four insurance carriers claims for the 2019 program year. The SOS concluded the audit with no actions taken.

Section 5: Public Input

A. Public forums

- I. On July 21, 2021, DCBS held a public forum to inform the general public of the current status of the ORP and our intent to extend this vital program (Appendix 5). The event was virtual due to COVID-19 protocols, opened public comment on this waiver extension request and posted notice of the opportunity to comment on the ORP website at <https://dfr.oregon.gov/business/reg/health/pages/oregon-reinsurance-program.aspx>
- II. On Jan. 27, 2022, a notice was sent to the Oregon's Health Insurance Marketplace Advisory Committee (HIMAC), which consist of stakeholders from around the state, as well as Oregon tribal liaisons, with details about the extension.

DCBS sent notice via email to its list of interested parties and stakeholders. DCBS received eight written public comments on this waiver extension request (Appendix 3).

B. Tribal consultation

On Jan. 12, 2022, DCBS attended the Legislative Commission on Indian Services (LCIS) to inform the nine federally recognized tribes in Oregon of the extension of the ORP Waiver (Appendix 4). During that meeting a presentation was given to the tribes, of which 36 were in attendance. The presentation was posted on the ORP website at <https://dfr.oregon.gov/business/reg/health/Documents/reinsurance-program/Oregon-Tribal-Consultation-Reinsurance-Program.pdf> for further consideration.

Conclusion

The Oregon Reinsurance Program has been successful during our current waiver period, reducing premiums more than 8.2 percent on average statewide for Oregonians who purchased insurance on the individual market. Access to health care remains a key goal and our health care market has been stable during the reinsurance program period. The impact of the COVID-19 pandemic reinforces the need to continue Oregon's waiver in order to ensure stability, affordability, access, and comprehensive health plans on the health care marketplace. Thank you for considering our application and supporting Oregon's health care goals for high-quality care at affordable prices.

Appendix 1

80th OREGON LEGISLATIVE ASSEMBLY—2019 Regular Session

Enrolled House Bill 2010

Sponsored by Representative RAYFIELD, Senators STEINER HAYWARD, JOHNSON

CHAPTER

AN ACT

Relating to funding to improve access to health care; creating new provisions; and amending ORS 243.135 and sections 10, 12, 13 and 14, chapter 736, Oregon Laws 2003, section 2, chapter 26, Oregon Laws 2016, and sections 3, 4, 5, 6, 8, 9, 12, 19, 41 and 48, chapter 538, Oregon Laws 2017.

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

OREGON REINSURANCE PROGRAM

SECTION 1. Section 19, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 19. (1) As used in this section:

(a) “Attachment point” means the threshold dollar amount, adopted by the Department of Consumer and Business Services by rule, for claims costs incurred by a reinsurance eligible health benefit plan for an insured individual’s covered benefits in a benefit year, after which threshold the claims costs for the benefits are eligible for reinsurance payments.

(b) “Coinsurance rate” means the rate, adopted by the department by rule, at which the department will reimburse a reinsurance eligible health benefit plan for claims costs incurred for an insured individual’s covered benefits in a benefit year after the attachment point and before the reinsurance cap.

(c) “Health benefit plan” has the meaning given that term in ORS 743B.005.

(d) “Reinsurance cap” means the threshold dollar amount, adopted by the department by rule, for claims costs incurred by a reinsurance eligible health benefit plan for an insured individual’s covered benefits in a benefit year, after which threshold the claims costs for the benefits are no longer eligible for state reinsurance payments.

(e) “Reinsurance eligible health benefit plan” means a health benefit plan providing individual coverage that:

(A) Is delivered or issued for delivery in this state; and

(B) Is not a grandfathered health plan as defined in ORS 743B.005.

(f) “Reinsurance eligible individual” means an individual who is insured in a reinsurance eligible health benefit plan [on or after January 1, 2018].

(2) An issuer of a reinsurance eligible health benefit plan becomes eligible for a reinsurance payment when the claims costs for a reinsurance eligible individual’s covered benefits in a calendar year exceed the attachment point. The amount of the payment shall be the product of the coinsurance rate and the issuer’s claims costs for the reinsurance eligible individual that exceed the attachment point, up to the reinsurance cap.

Enrolled House Bill 2010 (HB 2010-A)

(3) After the department adopts by rule the attachment point, reinsurance cap or coinsurance rate, the department may, *[not]* **only if necessary to pay out the full amount of funding budgeted for the Oregon Reinsurance Program when claims received are less than the amount of claims that were projected:**

(a) Change the attachment point *[or the reinsurance cap]* during that benefit year; or

(b) Increase the coinsurance rate during the benefit year.

(4) The department may adopt rules necessary to carry out the provisions of this section including, but not limited to, rules prescribing:

(a) The amount, manner and frequency of reinsurance payments; and

(b) Reporting requirements for issuers of reinsurance eligible health benefit plans.

SECTION 2. Section 2, chapter 26, Oregon Laws 2016, as amended by section 24, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 2. The Department of Consumer and Business Services shall have sole authority to apply for a waiver for state innovation under 42 U.S.C. 18052. The department shall apply for a waiver to receive funding to implement the Oregon Reinsurance Program established in section 18, *[of this 2017 Act]* **chapter 538, Oregon Laws 2017, and apply for subsequent renewals of the waiver to continue the program as long as revenue from the assessment under section 5, chapter 538, Oregon Laws 2017, is available.**

SECTION 3. Section 48, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 48. Sections 18 to 22, *[of this 2017 Act]* **chapter 538, Oregon Laws 2017,** are repealed on January 2, *[2024]* **2028.**

HEALTH INSURANCE PREMIUM AND MANAGED CARE ASSESSMENTS

SECTION 4. Section 3, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 3. (1) As used in this section:

(a) “Insured” means an eligible employee or family member, as defined in ORS 243.105, who is enrolled in a self-insured health benefit plan under ORS 243.105 to 243.285.

(b) “Premium equivalent” means a claim for reimbursement of the cost of a health care item or service provided to an *[eligible employee or family member]* **insured**, other than a dental or vision care item or service, and the administrative costs associated with the claim.

(2) No later than 45 days following the end of a calendar quarter, the Public Employees’ Benefit Board shall pay an assessment at the rate of *[1.5]* **two** percent on the gross amount of premium equivalents received during the calendarquarter.

(3) The assessment shall be paid to the Department of Consumer and Business Services and shall be accompanied by a verified report, on a form prescribed by the department, together with any information required by the department.

(4) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on the board.

(5) If the department determines that the assessment paid by the board under this section is incorrect, the department shall charge or credit to the board the difference between the correct amount of the assessment and the amount paid by the board.

(6) The board is entitled to notice and an opportunity for a contested case hearing under ORS chapter 183 to contest an action of the department taken pursuant to subsection (5) of this section.

(7) Moneys received by the department under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2, *[of this 2017 Act]* **chapter 538, Oregon Laws 2017.**

SECTION 5. Section 4, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 4. Section 3, *[of this 2017 Act]* **chapter 538, Oregon Laws 2017,** applies to premium equivalents received by the Public Employees’ Benefit Board, or a third party administrator that

contracts with the board to administer a self-insured health benefit plan, during the period from January 1, [2018] **2020**, through December 31, [2019] **2026**.

SECTION 6. Section 5, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 5. (1) As used in this section:

(a) "Gross amount of premiums" has the meaning given that term in ORS 731.808.

(b) "Health [benefit] plan" [has the meaning given that term in ORS 743B.005.] means:

(A) A health benefit plan as defined in ORS 743B.005; and

(B) Insurance described in ORS 742.065.

(2) No later than 45 days following the end of a calendar quarter, an insurer shall pay an assessment at the rate of [1.5] **two** percent of the gross amount of premiums earned by the insurer during that calendar quarter that were derived from health [benefit] plans delivered or issued for delivery in Oregon.

(3) The assessment shall be paid to the Department of Consumer and Business Services and shall be accompanied by a verified form prescribed by the department together with any information re- quired by the department, that reports:

(a) All health [benefit] plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid; and

(b) The gross amount of premiums by line of insurance, derived by the insurer from all health [benefit] plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid.

(4) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on an insurer.

(5) Any rate filed for the department's approval may include amounts paid by the insurer under this section as a valid element of administrative expense or retention.

(6) Moneys received by the department under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2, [of this 2017 Act] **chapter 538, Oregon Laws 2017**.

SECTION 7. Section 6, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 6. (1) If the Public Employees' Benefit Board [or an insurer] fails to timely file a verified form or to pay an assessment required under section 3, [or 5 of this 2017 Act] **chapter 538, Oregon Laws 2017**, the Department of Consumer and Business Services shall impose a penalty on the board [or insurer] of up to \$500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for thatcalendar quarter.

(2) If an insurer fails to timely file a verified form or to pay an assessment required under section 5,chapter 538, Oregon Laws 2017, the department shall impose a penalty on the insurer of the greater of:

(a) An amount determined under ORS 731.988; or

(b) Five percent of the assessment due for the calendar quarter.

[2] **(3)** Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under sections 3 and 5, [of this 2017 Act] **chapter 538, Oregon Laws 2017**.

SECTION 8. Section 8, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 8. [(1)] Section 5, [of this 2017 Act] **chapter 538, Oregon Laws 2017**, applies to premiums earned by an insurer for [a period of eight calendar quarters beginning on the date, on or after January 1, 2018, that the policy or certificate for which the premiums are paid is issued or renewed] **the period beginning January 1, 2020, and ending December 31,2026**.

[(2)] *Notwithstanding any provision of contract or statute, including ORS 743B.013 and 743.022, insurers may increase their premium rate on policies or certificates that are subject to the assessment under section 5 of this 2017 Act by 1.5 percent. If an insurer increases its rates under this subsection, the insurer may include in its billings for health benefit plans a notice, as prescribed by the Department of Consumer and Business Services, explaining that the increase is due to the assessment under section 5 of this 2017 Act.*

SECTION 9. Section 9, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 9. (1) As used in this section and sections 10 and 11, *[of this 2017 Act]* **chapter 538,**

Oregon Laws 2017:

(a) “Managed care organization” means:

(A) A coordinated care organization as defined in ORS 414.025; and

(B) A prepaid managed care health services organization as defined in ORS 414.025.

(b) “Premium equivalent” means the payments made to the managed care organization by the Oregon Health Authority for providing health services under ORS chapter 414.

(2) No later than 45 days following the end of a calendar quarter, a managed care organization shall pay an assessment at a rate of *[1.5]* **two** percent of the gross amount of premium equivalents received during that calendar quarter.

(3) The assessment shall be paid to the authority in a manner and form prescribed by the authority.

(4) Assessments received by the authority under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2, *[of this 2017 Act]* **chapter 538, Oregon Laws 2017.**

(5) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on a managed care organization.

SECTION 10. Section 12, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 12. Sections 9, 10 and 11, *[of this 2017 Act]* **chapter 538, Oregon Laws 2017,** apply to any payments made to a managed care organization by the Oregon Health Authority for the period beginning January 1, *[2018]* **2020,** and ending December 31, *[2019]* **2026.**

SECTION 11. ORS 243.135, as amended by section 27, chapter 746, Oregon Laws 2017, is amended to read:

243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public Employees’ Benefit Board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees, the state and the local governments. In considering whether to enter into a contract for a plan, the board shall place emphasis on:

(a) Employee choice among high quality plans;

(b) A competitive marketplace;

(c) Plan performance and information;

(d) Employer flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

(g) Plan benefits as part of total employee compensation;

(h) The improvement of employee health; and

(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan.

(2) The board may approve more than one carrier for each type of plan contracted for and offered but the number of carriers shall be held to a number consistent with adequate service to eligible employees and their family members.

(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members who are not enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board. An eligible employee who declines coverage in a health benefit plan offered by the Public Employees’ Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse or family member in another health benefit plan offered by the Public Employees’ Benefit Board or the Oregon Educators Benefit Board may not be paid the employer contribution for the plan that was declined.

Enrolled House Bill 2010 (HB 2010-A)

(4) Payroll deductions for costs that are not payable by the state or a local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

(5) In developing any health benefit plan, the board may provide an option of additional coverage for eligible employees and their family members at an additional cost or premium.

(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and their family members under rules adopted by the board. Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

(7) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

(8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by the board that are designed to limit the growth in per-member expenditures for health services to no more than 3.4 percent per year. **The assessment paid in accordance with section 3, chapter 538, Oregon Laws 2017, shall be excluded in determining the 3.4 percent annual increase in per-member expenditures for health services.**

(b) The board shall adopt policies and practices designed to limit the annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.

(9) A carrier or third party administrator that contracts with the board to provide or administer a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.

(10) By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care.

(11) No later than February 1 of each year, the board shall report to the Legislative Assembly on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care.

SECTION 12. ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, and section 27, chapter 746, Oregon Laws 2017, is amended to read:

243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees, the state and the local governments. In considering whether to enter into a contract for a plan, the board shall place emphasis on:

- (a) Employee choice among high quality plans;
- (b) A competitive marketplace;
- (c) Plan performance and information;
- (d) Employer flexibility in plan design and contracting;
- (e) Quality customer service;
- (f) Creativity and innovation;
- (g) Plan benefits as part of total employee compensation;
- (h) The improvement of employee health; and
- (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan.

(2) The board may approve more than one carrier for each type of plan contracted for and offered but the number of carriers shall be held to a number consistent with adequate service to eligible employees and their family members.

(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members who are not

enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board. An eligible employee who declines coverage in a health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse or family member in another health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board may not be paid the employer contribution for the plan that was declined.

(4) Payroll deductions for costs that are not payable by the state or a local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

(5) In developing any health benefit plan, the board may provide an option of additional coverage for eligible employees and their family members at an additional cost or premium.

(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and their family members under rules adopted by the board. Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

(7) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

(8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by the board that are designed to limit the growth in per-member expenditures for health services to no more than 3.4 percent per year. **The assessment paid in accordance with section 3, chapter 538, Oregon Laws 2017, shall be excluded in determining the 3.4 percent annual increase in per-member expenditures for health services.**

(b) The board shall adopt policies and practices designed to limit the annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.

(9) A carrier or third party administrator that contracts with the board to provide or administer a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.

(10) If the board spends less than 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care, the board shall implement a plan for increasing the percentage of total medical expenditures spent on payments for primary care by at least one percent each year.

(11) No later than February 1 of each year, the board shall report to the Legislative Assembly on any plan implemented under subsection (10) of this section and on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care.

EXTENSION OF HOSPITAL ASSESSMENT

SECTION 13. Section 10, chapter 736, Oregon Laws 2003, as amended by section 3, chapter 780, Oregon Laws 2007, section 20, chapter 867, Oregon Laws 2009, section 8, chapter 608, Oregon Laws 2013, section 2, chapter 16, Oregon Laws 2015, and section 37a, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 10. Sections 1 to 9, chapter 736, Oregon Laws 2003, apply to net revenues earned by hospitals during a period beginning [October 1, 2015] **July 1, 2019**, and ending the earlier of September 30, [2021] **2025**, or the date on which the assessment no longer qualifies for federal financial participation under Title XIX or XXI of the Social Security Act.

SECTION 14. Section 12, chapter 736, Oregon Laws 2003, as amended by section 4, chapter 780, Oregon Laws 2007, section 21, chapter 867, Oregon Laws 2009, section 9, chapter 608, Oregon Laws

2013, section 3, chapter 16, Oregon Laws 2015, and section 38, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 12. (1) Sections 1 to 9, chapter 736, Oregon Laws 2003, are repealed on January 2, [2026] 2031.

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

SECTION 15. Section 13, chapter 736, Oregon Laws 2003, as amended by section 5, chapter 780, Oregon Laws 2007, section 22, chapter 867, Oregon Laws 2009, section 10, chapter 608, Oregon Laws 2013, section 4, chapter 16, Oregon Laws 2015, and section 39, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 13. Nothing in the repeal of sections 1 to 9, chapter 736, Oregon Laws 2003, and section 1, chapter 608, Oregon Laws 2013, by section 12, chapter 736, Oregon Laws 2003, affects the imposition and collection of a hospital assessment under sections 1 to 9, chapter 736, Oregon Laws 2003, for a calendar quarter beginning before September 30, [2021] 2025.

SECTION 16. Section 14, chapter 736, Oregon Laws 2003, as amended by section 6, chapter 780, Oregon Laws 2007, section 23, chapter 867, Oregon Laws 2009, section 5, chapter 16, Oregon Laws 2015, and section 40, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 14. Any moneys remaining in the Hospital Quality Assurance Fund on December 31, [2025] 2031, are transferred to the General Fund.

OREGON HEALTH AND SCIENCE UNIVERSITY REIMBURSEMENT

SECTION 17. Section 41, chapter 538, Oregon Laws 2017, is amended to read:

Sec. 41. The Oregon Health Authority shall ensure that the Oregon Health and Science University receives net reimbursement of at least [84] 87 percent but no more than 100 percent of the university's costs of providing services that are paid for, in whole or in part, with Medicaid funds. Net reimbursement means all Medicaid payments less any amount that is transferred by the university to the authority.

SECTION 18. Section 41, chapter 538, Oregon Laws 2017, as amended by section 17 of this 2019 Act, is amended to read:

Sec. 41. The Oregon Health Authority shall ensure that the Oregon Health and Science University receives net reimbursement of at least [87] 84 percent but no more than 100 percent of the university's costs of providing services that are paid for, in whole or in part, with Medicaid funds. Net reimbursement means all Medicaid payments less any amount that is transferred by the university to the authority.

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

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

CAPTIONS

SECTION 20. **The unit captions used in this 2019 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2019 Act.**

Passed by House February 19, 2019

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

.....
Tina Kotek, Speaker of House

Passed by Senate February 28, 2019

.....
Peter Courtney, President of Senate

Received by Governor:

.....M,....., 2019

Approved:

.....M,....., 2019

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M,....., 2019

.....
Secretary of State

Appendix 2

OFFICE OF THE SECRETARY OF STATE
SHEMIA FAGAN
SECRETARY OF STATE

CHERYL MYERS
DEPUTY SECRETARY OF STATE



ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-

PERMANENT ADMINISTRATIVE ORDER

ID 12-2021
CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILED
12/16/2021 4:13 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Amendment to Oregon Reinsurance Program Payment Parameters for 2022

EFFECTIVE DATE: 01/01/2022

AGENCY APPROVED DATE: 12/16/2021

CONTACT: Karen Winkel
503-947-7694
karen.j.winkel@dcbs.oregon.gov

350 Winter Street NE
Salem, OR 97301

Filed By:
Karen Winkel
Rules Coordinator

AMEND: 836-150-0040

NOTICE FILED DATE: 10/29/2021

RULE SUMMARY: Amending to increase the attachment point for 2022 to \$92,000 but extend all other payment parameters from 2021 to cover claims made during the 2022 benefit year.

CHANGES TO RULE:
836-150-0040

Reinsurance Parameters

- (1) For the benefit year beginning on January 1, 2018 the parameters for the Oregon Reinsurance Program are:
 - (a) An attachment point of \$95,000;
 - (b) A reinsurance cap of \$1,000,000; and
 - (c) A coinsurance rate of 59.2 percent.
- (2) For the benefit year beginning on January 1, 2019 the parameters for the Oregon Reinsurance Program are:
 - (a) An attachment point of \$90,000;
 - (b) A reinsurance cap of \$1,000,000; and
 - (c) A coinsurance rate of fifty percent.
- (3) For the benefit year beginning on January 1, 2020 the parameters for the Oregon Reinsurance Program are:
 - (a) An attachment point of \$90,000;
 - (b) A reinsurance cap of \$1,000,000; and
 - (c) A coinsurance rate of fifty percent.
- (4) For the benefit year beginning on January 1, 2021 the parameters for the Oregon Reinsurance Program are:
 - (a) An attachment point of \$83,000;
 - (b) A reinsurance cap of \$1,000,000; and
 - (c) A coinsurance rate of fifty percent.
- (5) For the benefit year beginning on January 1, 2022 the parameters for the Oregon Reinsurance Program are:
 - (a) An attachment point of \$92,000;
 - (b) A reinsurance cap of \$1,000,000; and
 - (c) A coinsurance rate of fifty percent

Statutory/Other Authority: ORS 731.244, Or Laws 2017, ch 538, sec 19
Statutes/Other Implemented: Or Laws 2017, ch 538, sec 18-21

Appendix 3



KATE BROWN
Governor

October 8, 2021

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Becerra,

I am writing to express my support for extending Oregon's 1332 Waiver for program years 2023 through 2027. The 1332 waiver has been vital to stabilizing the state's individual health insurance market through the Oregon Reinsurance Program. Over the past four years, our reinsurance program – one of the first approved and implemented – has been key to the success of Oregon's health care system and the overall health of the approximately 180,000 middle-income Oregonians who purchase insurance on their own. For the 2022 program year and beyond, Oregonians will continue to save up to 8.5 percent on health plans purchased on the individual market. This has helped expand carrier competition in rural areas and provided multiple health plan options for people living in every county of the state.

In Oregon, we believe that access to health care is the foundation of personal and community success. We are fully committed to ensuring all Oregonians have quality, affordable health care, regardless of who they are or where they live.

The Oregon Reinsurance Program has been a key component of our mission to maintain health care coverage for 99 percent of adults and 100 percent of kids. It has encouraged competitor growth in all areas of the state, with at least three carriers in each of our 36 counties. Despite all of the challenges to the ACA and market stability, the reinsurance program has provided certainty and trust for both Oregonians and health insurers by lowering costs, expanding services, and stabilizing the market.

More work lies ahead to continue the progress Oregon has made in implementing its 1332 waiver. Our goal is to use all available measures to meet our coverage goals and ensure that every Oregonian has access to quality, affordable health care across our large, diverse state. The U.S. Department of Health and Human Services approval of our waiver extension for the next five years is a critical step in the continual improvement of Oregon's commercial insurance market. We look forward to continuing to work with you on this waiver program and other initiatives that provide Oregonians with quality, affordable health care.

Sincerely,

Governor Kate Brown



Phone Number | (866) 554-5360
aarp.org/or | oraarp@aarp.org | twitter:@aarpor
facebook.com/AARPOregon

October 11, 2021

Andrew Stolfi
Oregon Insurance Commissioner and DCBS Director
350 Winter Street NE.
Salem, Oregon 97309

Dear Commissioner Stolfi:

AARP Oregon writes to express our continued support for the Oregon State Relief and Empowerment PPACA 1332 Waiver in its application for program years 2023-2027. This 1332 waiver permits Oregon to operate the Oregon Reinsurance Program – a program that has helped drive down health care premiums while expanding more affordable, quality health insurance coverage throughout the state.

We are encouraged by the savings of approximately \$270 million that Oregonians purchasing individual coverage achieved between 2018 and 2020. Stabilizing the individual health insurance market is critical to the long-term access to coverage for all Oregonians and the Oregon Reinsurance Program provides that stability by reimbursing insurance carriers for a portion of high cost claims incurred by policy holders.

We thank you for the opportunity to share our continued support for Oregon's 1332waiver renewal and we look forward to continuing to work together in order to ensure affordable, quality health insurance coverage for all Oregonians.

Thank you again and please feel free to reach out to me if you have any questions
BShrestha@aarp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "BShrestha".

Bandana Shrestha
State Director, AARP Oregon



August 11th, 2021

Oregon Insurance Commissioner Andrew Stolfi
Oregon Department of Consumer & Business Services
350 Winter Street NE, Room 200
PO Box 14480
Salem, OR 97309-0405

RE: Extension of the Oregon Section 1332 State Innovation Waiver

Dear Commissioner Stolfi,

I am writing on behalf of Moda Health to voice our support for a five-year extension of the Oregon Section 1332 State Innovation Waiver and the Oregon Reinsurance Program (ORP). Moda Health has participated in the Oregon individual market since prior to establishment of the Affordable Care Act (ACA) and has continued its participation under the ACA, both on and off the exchange. We supported establishment of the ORP and continue to see a vital need for the program to improve the affordability and stability of the individual market in Oregon.

Consumers need health insurance that is consistently affordable and a market that is stable to maintain health care coverage. As you reference in your letter to the Secretary of the Treasury and the Secretary of Health and Human Services, the ORP has successfully lowered individual market premiums between 7.5 percent and 8.5 percent from 2018 to 2020. As such it directly improves the affordability of the market. The ORP also contributes to the stability of Oregon's individual market as affordability leads to increased enrollment and increased enrollment makes the market a more viable place for Oregon's health insurers to offer plans, thereby increasing consumer options. Today, Oregon individual market consumers can choose from a large variety of health plan issuers and plan options, thanks in large part to the stabilizing presence of the ORP.

The ORP, and the 1332 State Innovation Waiver that enables it, should be extended for another five years to continue to support affordability and stability in Oregon's individual market.

*Health plans provided by Moda Health Plan, Inc.
Individual medical plans in Alaska provided by Moda Assurance Company.*

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read 'K Anderson', written in a cursive style.

Kraig Anderson
Senior Vice President and Chief Actuary
Moda Health Plan, Inc.



Tom Holt
tom@theholtcompany.com
503-956-7461

August 26, 2021

Mr. Andrew Stolfi
Oregon Insurance Commissioner and DCBS Director
350 Winter Street NE.
Salem Oregon, 97309
Attention: Joel Payton, ORP Program Manager

Dear Commissioner Stolfi:

I am writing on behalf of the Oregon Association of Health Underwriters – the professional association of insurance professionals dedicated to serving the public through strengthening the insurance marketplace – in support of the Department of Consumer and Business Services’ application to the federal government to renew the state’s reinsurance waiver for the Individual market.

Since its adoption, Oregon’s reinsurance program has proven its effectiveness as a stabilizer in the Individual ACA market, and it has helped a great deal to mitigate premium costs. As a result, Oregon has a remarkable degree of carrier participation in the marketplace and a very high percentage of the population covered by insurance.

This program is particularly important as the continuing evolution of our economy and technology enable more people to work independently, and many of them need Individual coverage.

OAHU urges all the federal agencies involved to approve Oregon’s reinsurance waiver application.

As always, please let us know if we can be of any further assistance on this important issue.

Best regards,

Tom Holt

for Oregon Association of Health Underwriters



Oregon Reinsurance Program

Re: Oregon Reinsurance Program and 1332 State Innovation Waiver

August 23, 2021

Dear Mr. Andrew Stolfi:

Project Access NOW's (PANOW) mission is to improve our communities' health and wellbeing by creating access to care, services, and resources for those most in need. PANOW offers a suite of programs that connect our clients to donated care, health coverage, low to no-cost medications and goods/services that help them safely and securely discharge from the hospital or utilize their health-related service dollars.

Our Premium Assistance (PA) help pays health insurance premiums for clients who earn slightly too much to qualify for Medicaid, but too little to afford premiums and out-of-pocket costs. In the month of August 2021, 687 clients who cannot afford premium payments were served by Premium Assistance (PA) program. Our other program, Outreach, Enrollment, and Access (OEA) helps uninsured Oregonians enroll in health insurance and navigate the federal marketplace and other qualifying state programs. Since 2019, Outreach, Enrollment, and Access (OEA) has enrolled just under 1,000 individuals in gold level Kaiser health insurance.

Through these programs we have seen that our clients are positioned to equitably access health care and other services associated with their overall well-being.

We are in support of PPACA 1332 State Innovation Waivers as authorized by the United States Department of Health and Human Services and United States Treasury for another five-year term. We are hopeful that the comment we have put forth will add to the important voices of our fellow Oregonians, community based and social service organizations, and individuals mostly impacted by the inequities the system aims to reduce.

We are excited to be part of this conversation and look forward to continuing to be a partner.

Yours,

Carly Hood-Ronick, MPA, MPH

Executive Director



Regence

P.O. Box 1271
Portland, OR 97207-1271

August 20, 2021

The Honorable Xavier Becerra
Secretary, U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Becerra:

Regence BlueCross BlueShield (“Regence”) appreciates the opportunity to support Oregon’s 1332 State Innovation Waiver and we respectfully request that the program be approved and extended through 2027.

Regence has served Oregon and its residents for 80 years, including 940,000 Oregonians last year. We have proudly cultivated a reputation for providing person-focused, economically sustainable health plans. Not only do we support health care solutions for our members, but we proactively seek solutions that would improve health care for all Oregonians.

We supported the original 1332 State Innovation Waiver from Oregon’s Department of Consumer and Business Services (DCBS) that established the Oregon Reinsurance Program. At the time, we believed it was a sound solution to address the affordability challenges our members were experiencing in the individual market.

We are pleased to report that the Oregon Reinsurance Program has delivered on its affordability goals. We agree with DCBS’s estimates and concur that the Oregon Reinsurance Program has lowered consumer premiums by a net of 6.5 percent throughout the period of operation.

We strongly encourage the U.S. Department of Health and Human Services to approve the next waiver request so this valuable program may continue. Approval of the waiver will continue to stabilize the individual market in Oregon and deliver meaningful benefits to consumers.



Regence |

P.O. Box 1271
Portland, OR 97207-1271

We appreciate and share your commitment to a more affordable and equitable health care system and look forward to working with you on future improvements. Please contact me (alison.esquea@cambiahealth.com) or Vince Porter, our Director of Public Affairs and Government Relations (vince.porter@cambiahealth.com), with any questions.

Sincerely,

Alison Esquea

Alison Esquea
Vice President, Federal Affairs
Cambia Health Solutions

Cc: Andrew Stolfi, Insurance Commissioner Oregon Department of
Consumer and Business Services

To: Oregon Dept. of Consumer and Business Services – Division of Financial Regulation

From: Maribeth Guarino, Health Care Advocate

Date: August 13, 2021

Re: Oregon § 1332 waiver & reinsurance program

OSPIRG strongly supports the renewal of Oregon’s § 1332 waiver & reinsurance program, and we look forward to the program’s continued stabilization of the health insurance market and the consumer protection it offers.

The reinsurance program benefits Oregonians across the state. With the program in place, insurance companies’ risk is reduced, meaning they can afford to lower their insurance premiums. Even with the program, insurance premiums have risen, but they have risen much slower. From 2016-2018, rates increased by an average of 18.4 percent each year. From 2019-2021, the rates increased an average of 3.6 percent , and some rates even decreased.¹

For consumers, this makes all the difference. Nearly 39 percent of Oregonians have taken detrimental actions such as delaying appointments or treatment due to the cost.² More than 141,000 Oregonians are covered through the individual marketplace, and many still struggle to pay their premiums each month.³ Some, like Abby G., have had to downgrade from Gold or Silver plans to bronze or even catastrophic care so they can afford the monthly premiums.⁴ Thus far, Oregon has managed to decrease our uninsured numbers to just 6 percent .⁵ Without the reinsurance program to help keep prices down, consumers may not be able to pay the premium at all, negatively affecting that number as prices rise.

Similarly, the assistance from the reinsurance program is an incentive to keep insurers in the individual marketplace, which is important to maintaining competition. More insurers in the

¹ Based on average filings from the Oregon Department of Financial Regulation.
<https://dfr.oregon.gov/healthrates/Pages/find-filing.aspx>

² “Oregon Attitudes on Health Care.” OSPIRG. May 2021.
<https://ospirg.org/sites/pirg/files/reports/FINAL%20-%20Oregon%20Attitudes%20on%20Health%20Care%20-%20May%202021.pdf>

³ “Oregon Marketplace Annual Report Summary: 2020.” Oregon Health Authority.
<https://healthcare.oregon.gov/Documents/2020%20OHIM%20Executive%20Summary.pdf> ⁴

“Voices for Better Care: Abby G.” OSPIRG. February 2021.
<https://voicesforbettercare.org/post/643406972002189312/abby-g-says-my-alimony-plus-retirement-account>

⁵ “Percentage of people with health insurance remains high, according to Oregon Health Insurance Survey.” Oregon Health Authority. September 2019.

<https://www.oregon.gov/oha/ERD/Pages/2019-Oregon-Health-Insurance-Survey.aspx>

marketplace promotes lower prices, benefitting Oregonians across the state.⁶ In 2017, there was a downtrend in insurers participating in the marketplace in Oregon, decreasing from ten to six. In 2018, there were only five.⁷ This number varied by county, but as recently as 2020 more than half of Oregon counties had only two insurers offering plans.⁸ This can lead to higher premiums and health care costs for consumers.⁹ In 2021, only one county had less than four insurers.¹⁰ The reinsurance program is a useful tool to incentivize this competition.

Recently, the American Rescue Plan Act (ARPA) introduced significantly increased premium subsidies to help individuals and families afford health insurance. This is an incredible help to many Oregonians, especially during the COVID-19 pandemic. However, the ARPA subsidies are set to expire at the end of 2022, and there are no guarantees that the federal government will make them a permanent part of the marketplace. The reinsurance program provides a backup consumer protection - an inbuilt risk-protection program that trickles down to the prices consumers actually pay on the marketplace.

On behalf of Oregon consumers, OSPIRG thanks the Oregon legislature for authorizing the renewal of the reinsurance program and the Department of Consumer & Business Services for their efforts in administering it. We urge the federal government to take notice of the program's success thus far and the benefits it offers to Oregonians. The Oregon application for a federal grant to renew the reinsurance program should be approved.

⁶ "Creating a New Competitive Health Insurance Marketplace." Centers for Medicare and Medicaid Services. <https://www.cms.gov/CCIIO/Resources/Marketplace-Grants>

⁷ Daniel McDermott & Cynthia Cox. "Insurer Participation on the ACA Marketplaces, 2014-2021." Kaiser Family Foundation. November 2020. <https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/>

⁸ "2020 Health Insurance Rate Requests." Oregon Department of Consumer & Business Services. July 2019. <https://dfr.oregon.gov/healthrates/Documents/2020-individual-coverage.pdf>

⁹ Meg Bryant. "Market concentration tied to higher premiums in ACA markets, study finds." Health Care Dive. August 2018. <https://www.healthcaredive.com/news/market-concentration-tied-to-higher-premiums-in-aca-markets-study-finds/529488/>

¹⁰ "2021 Health Insurance Rate Requests." Oregon Department of Consumer & Business Services. July 2020. <https://dfr.oregon.gov/healthrates/Documents/2021-rate-and-county-coverage.pdf>



August 24, 2021

Andrew Stolfi, Oregon Insurance Commissioner and DCBS Director
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309

Delivered via email: Andrew.Stolfi@Oregon.gov

Re: Oregon Reinsurance Program Public Comments for 2023-2027 PPACA § 1332 Waiver Extension

Dear Commissioner Stolfi:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 500,000 commercial, Medicaid, and Medicare Advantage members in four states. PacificSource Community Solutions is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia River Gorge, Marion & Polk Counties, and Lane County. Our mission is to provide better health, better care, and better value to the people and communities we serve.

Thank you for the opportunity to comment on the Department of Consumer and Business Services' application to extend the state's § 1332 waiver for program years 2023-2027. As you know, the waiver implemented Oregon law¹ that directed the creation of the Oregon Reinsurance Program. The program allows health benefit plans to receive a reinsurance payment when claims costs exceed the established attachment point. Oregon was one of the first states to successfully implement a reinsurance program, and it has served as a model ever since.

PacificSource writes to express our support for the extension of the waiver. Oregon's approach to reinsurance has proven to be an efficient and effective method of controlling health care costs. The magnitude of the funding generated by the Oregon Reinsurance Program significantly lowers premiums and helps stabilize the insurance market. The reinsurance mechanism established in state law (i.e., the attachment point, coinsurance rate and reinsurance cap) is simple and effective. This simplicity in design ensures funds are distributed equitably and predictably among market participants while minimizing administrative burden. The Oregon Reinsurance Program demonstrates the value and promise of public/private partnerships designed for the betterment of Oregonians.

¹ 2017 Or Laws ch 538 (Enrolled House Bill 2391); 2019 Or Laws ch 2 (Enrolled House Bill 2010).

As you know, the department works to ensure access to fair products and services. The Oregon Reinsurance Program helps to accomplish this goal through encouraging multiple insurance carriers offer plans throughout the state. For example, PacificSource Health Plans offered plans in the individual market in only six counties in 2018, but in part through the support of the Oregon Reinsurance Program PacificSource now offers health plans on the individual market statewide.

Thank you for considering our comments. For questions or concerns, please contact Richard Blackwell, Director of Oregon Government Relations at 503.949.3620 or richard.blackwell@pacificsource.com.

Sincerely,

A handwritten signature in black ink, appearing to read "Ken P. Provencher". The signature is fluid and cursive, with the first name "Ken" being the most prominent.

Kenneth P. Provencher
President and CEO

Cc: TK Keen, Administrator, Division of Financial Regulation
Joel Payton, Oregon Reinsurance Program Manager

Appendix 4

Oregon Reinsurance Program PPACA 1332

Waiver Extension

Oregon Tribal Consultation



Confederated Tribes of Ground Ronde
Coquille Indian Tribe
Klamath Tribes

Cow Creek Band of Umpqua Indians
Confederated Tribes of Siletz
Confederate Tribes of Warm Springs
Burns Paiute of Harney Count

Confederated Tribes of Umatilla Reservation

Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians

The Department of Consumer and Business Services



Oregon's largest
business regulatory
and consumer
protection agency.

ACA 1332 Waiver

- Purpose
- Extension period
- Progress
- Analysis
- Questions



Oregon PPACA 1332 State Empowerment and Innovation Waiver

- Purpose
 - Stabilize rates and premiums in individual market
 - Spreads risk of high-cost claims among all insurance companies
 - Helps fund Oregon's Medicaid Program

Reinsurance Program Overview

- Purpose

- Reduce health insurance premium prices for Oregon Tribes who buy Insurance on the individual market
- Expand health care services in every county throughout the state
- Stabilize and strengthen Oregon's Individual health insurance market
- Ensure Oregon's expanded essential health benefits help Oregon's native population thrive

- Legislative & State Authority

- HB 2010 (2019) give Oregon authority to operate program through 12/31/2027
- Current CMS Section 1332 Waiver authority runs through 12/31/2022
- Seeking Extension for 5 years 01/01/2023 through 12/31/2027
- Administered by the Oregon Department of Consumer and Business Services

- Program Funding

- Federal 'Pass Through Funding' and State funding HB2010 (2019) Reinsurance Program
- Budget neutral for both federal and state governments

Five-Year Waiver Extension

- **Authorized by Department of Health and Human Services and U.S. Department of Treasury**
- **Extension period (January 1, 2023 to December 31, 2027)**

Source: [Federal Register :: Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond](#)

Impact to Tribal Communities

- Special Option for members Coverage for nine Oregon Tribes** (HealthCare.gov)
- Year-round open enrollment
- Private plans with no out-of-pocket cost (\$77,250 annual income family offour)
- Private plans with reduced out of pocket cost (At any income level)

- Reinsurance does help reduce uncompensated care cost for these care providers by helping more Tribal Members afford health insurance

- 2018-2021 Enrollment Averaged 700~1000 lives
- Six health insurance carriers on the Individual Market.

- Oregon Insurances Carriers have an average of at least 3 servicers in zones 1 through 7 (36 counties)**

Source:

** <https://dfr.oregon.gov/news/2020/Pages/2021-health-plan-rates-final.aspx>

*** <https://healthcare.oregon.gov/marketplace/coverage/pages/tribes.aspx>

Impact to Tribal Communities

Affordability

Many Tribal Members are already protected from rate increases on the individual market's premium subsidies by purchasing qualified health plans on the ACA exchange.

For the rest:

Oregonian's save 8.5 to 9 percent per year because of the PPACA 1332 Waiver.

Comprehensiveness — Measured by Guardrails

Includes all: Individual health and grandfathered plans

- Essential Health Benefits: (ORS 731.097)
 - (1) Ambulatory patient Services
 - (2) Emergency Services
 - (3) Hospitalization
 - (4) Maternity and newborn care
 - (5) Mental health and substance use disorder services, including behavioral health treatment
 - (6) Prescription drugs
 - (7) Rehabilitative and habilitative services and devices
 - (8) Laboratory services.
 - (9) Preventive and wellness services and chronic disease management.
 - (10) Pediatric services, including oral and vision care.

Other Services included: Telehealth and Mental health parity.

Source: <https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin2014-01.pdf>

Analysis — Measured by Guardrails

Deficit Neutrality — The project federal spending net of federal revenues under the §1332 Waiver must be equal or lower than projected federal spending net of federal revenues in absence of the §1332 Waiver.

Actuarial and Economic analysis — Advance Premium Tax Credits (APTC)

- Analysis and supporting data, enrollment, premiums, and Exchange financial assistance by age, income, and type of policies.
- Description of the models used to produce these estimate, including data sources and quality of the data, key assumptions, and parameters for the 1332 state plan
- All modeling assumptions used, source of state specific data, and the rationale for any deviation from federal forecasts.

Public Input

Process: State must provide for a meaningful level of public input prior to submitting an application (extension). Including consultation with federally recognized tribes if applicable; the state and federal comment period should both be no less than 30 days.

Open: January 20, 2022

Closes: February 20, 2022.

Address:

Oregon Department of Consumer and Business Services

Office of the Oregon Insurance Commissioner

Director's Office 2nd floor

Salem, Oregon 97309

Questions?

Oregon Tribal Consultation

Reinsurance Program Website:

<https://dfr.oregon.gov/business/reg/health/pages/oregon-reinsurance-program.aspx>

Joel Payton

Reinsurance Program Manager

Division of Financial Regulation

Joel.J.Payton@DCBS.Oregon.gov

503-302-4795



Appendix 5

Oregon Reinsurance Program
PPACA 1332 Waiver Extension and
Post Award Forum

July 20, 2021

Virtual meeting being recorded



The Department of Consumer and Business Services



Oregon's largest
business regulatory
and consumer
protection agency.

DCBS Divisions

- Building Codes Division
- Division of Financial Regulation
- Oregon Health Insurance Marketplace
- Oregon OSHA
- Workers' Compensation Board
- Workers' Compensation Division

Background

- U.S. Department of Health and Human Services, U.S. Department of the Treasury- Govern the operation of the PPACA 1332 Waiver
- O.L. (2017) c.538 §18-25 Established the Oregon Reinsurance Program
- Purpose:
 - Stabilize rates and premiums in individual market
 - Spreads risk of high-cost claims among all insurance companies
 - Helps fund Oregon's Medicaid Program

Structure

- Attachment point model:
 - Reimburse qualifying Insurers a percentage of claims paid on behalf of Individual enrollee
 - Attachment point and cap
 - Coinsurance rate

ORP Parameters

- Attachment range \$90,000 to \$1 million (2020 PY)
- Coinsurance 50%

- Example:

Health care Claims = \$1,000,000
Attachment Point = -\$90,000
Eligible Claim = \$910,000
Coinsurance Rate = ÷50%
Reimbursement = \$455,000

Reinsurance funding

- Portion of the 2 percent (~0.3) assessment imposed on commercial health premiums.*
- Federal pass-through funding under Section 1332 waiver

Remainder — Intragovernmental agreements to fund Medicare*

Oregon 1332 waiver

- **Helps fund the reinsurance program**
- **Allows carriers to set rates (High cost claims)**
- **Pass-through of federal savings**
 - **Savings from reductions in federal spending on advanced premium tax credits**

Oregon 1332 waiver

CMS approved application in 2017 for five years.

Pass-through funding:

- **2018 - \$54,482,113 — Complete**
- **2019 - \$41,845,226 — Complete**
- **2020 - \$54,408,157 — Current**
- **2021 - \$73,723,375 — New Funding**

ORP projected annual budget

Projected per year:

- 2018 — \$90 million
- 2019 — \$95.4 million
- 2020 — \$101.8 million
- 2021 — \$107.8 million

DCBS Health care Claims Funding for 2020 P.Y.

- Eligible health care claims — Approx. \$96.6 million
- 2021 total funding — \$107.8 million
- Federal grant — \$54,408,157
- State support — \$53,591,843

Proposed payment parameters

- Reinsurance cap — \$1 million
- Coinsurance — 50%
- Attachment points:
 - 2018 — \$95,000
 - 2019 — \$90,000
 - 2020 — \$90,000
 - 2021 — \$83,000
 - 2022 — \$92,000

ORP effect on individual rates

As a result of ORP:

- Rates reduced by 8.5 to 9.0 percent
- Oregonians will save an projected \$102.8 million in 2021 premiums
- Similar savings expected in 2022

ACA 1332 Waiver

State Innovation and Empowerment Waiver
Extension
2023-2027

ACA 1332 Waiver

- Purpose
- Extension Period
- Progress
- Analysis
- Questions

Purpose- PPACA 1332 State Relief and Empowerment Waiver

- Provide more affordable private market coverage
- Encourage sustainable spending growth
- Foster innovation
- Support and empower those in need
- Promote consumer-driven health care

Five-Year Waiver Extension

- Federal Standard Terms and Conditions:
 - Authorized by Department of Health and Human Services and U.S. Department of Treasury
 - Extension period (January 1, 2023 to December 31, 2027)
 - **Source:** [Federal Register :: Patient Protection and Affordable Care Act: Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond](#)

Progress

Oregon's state relief and innovation
waiver measured by guardrails

Coverage
Affordability
Comprehensiveness
Deficit Neutrality

Coverage — measured by guardrails

Coverage:

On and Off the individual market

2018-2020 Enrollment Averaged 181,167.66*

Six health insurance carriers on the Individual Market.

Oregon Insurance carriers have an average of at least 3 servicers in zones 1 through 7 (36 counties)**

*Source: Oregon PPACA 1332 Annual Reports

** <https://dfr.oregon.gov/healthrates/documents/2021-rate-and-county-coverage.pdf>

Affordability — Measured by guardrails

Affordability:

Many Oregonian's are protected from rate increases on the individual market through premium subsidies from purchasing qualified health plans on the ACA exchange.

For the rest:

Oregonian's save 8.5 to 9 percent per year because of the PPACA 1332 Waiver.

Comprehensiveness- Measured by guardrails

Essential health benefits for all individual health plans

ORS 731.097 includes:

Ambulatory services	Prescription drugs
Emergency services	Rehabilitative and habilitative services
Hospitalization	Laboratory services
Maternity and new born care	Preventative and wellness services
Mental health and substance use disorders	Pediatric services

Other services included: Telehealth and mental health parity. Source:

<https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin2014-01.pdf>

Analysis — Measured by guardrails

Deficit neutrality — The project's net of federal spending under the §1332 waiver must be equal or lower than projected federal spending net in absence of the waiver.

Actuarial and economic analysis - Advance Premium Tax Credits (APTC)

- Analysis and supporting data
- Description of models used
- All modeling assumptions
- Source of state specific data
- Rationale for deviation from federal forecasts

Public input:

Process: State must provide for a meaningful level of public input prior to submitting an application (extension). Including consultation with federally recognized tribes.

State and federal comment period no less than 30 days.

Open: July 20, 2021

Closes: August 20, 2021.

Address:

Oregon Department of Consumer and Business Services

Office of the Oregon Insurance Commissioner

Director's Office 2nd floor

Salem, Oregon

97309

Questions

2021 Annual Pass — Through Funding
and PPACA 1332 Extension
Forum





NovaRest
ACTUARIAL CONSULTING

**NOVAREST REPORT TO THE OREGON
DEPARTMENT OF BUSINESS
SERVICES**

**HEALTH INSURANCE INDIVIDUAL
MARKET ACTUARIAL AND
ECONOMIC ANALYSIS FOR
OREGON'S 1332 WAIVER EXTENSION
APPLICATION**

April 2022



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I. EXECUTIVE SUMMARY

Intent of This Report

NovaRest Actuarial Consulting (NovaRest) was engaged by the Oregon Department of Business Services (DCBS) to develop the Actuarial and Economic Analysis for the State of Oregon’s Section 1332 Waiver extension application (1332 Waiver or Waiver). This actuarial report addresses one of the requirements listed in the CMS response to the Oregon’s Letter of Intent to apply for a five year extension of its current 1332 Waiver state reinsurance program. Reliance on this report should include a review of the full report and the report should only be reproduced in its entirety.

The Oregon 1332 Waiver Reinsurance Program

House Bill 2391, signed into law on July 5, 2017, established the Oregon Reinsurance Program (ORP) to be administered by the State of Oregon DCBS. The goal of the program was to address rising health insurance premiums in Oregon and to enhance and maintain individual market stability. Total funding for the ORP for 2018 was estimated to be approximately \$90 million. The ORP is funded through a 0.3 percent premium assessment levied on major medical premiums for policies issued in this state and through excess fund balances held in two state programs. Oregon sought federal pass-through funds – provided via net premium tax credit savings. CMS approved the application effective January 1, 2018 through December 31, 2022. Oregon is seeking approval for an extension of the waiver program through 2027. This report is part of that application. As with the original program, the waiver will continue to adhere to the guardrails established by Section 1332 and principles laid out in guidance from CMS.

More details on the methodology and assumptions used are contained below.

Reinsurance Mechanism

Under Oregon’s 1332 Waiver Extension, the ORP will continue to operate as it has since January 1, 2018. The program will continue unchanged in its structure or operations. It will continue to provide payments to Oregon individual ACA market issuers for a portion of the claims of high cost enrollees. Please see the report “Evaluation of the Oregon 1332 Waiver Reinsurance Program” included in the extension application materials for a description and evaluation of the ORP. The extended program will continue to be funded through a combination of state funding and federal pass-through funding.



Meeting the 1332 Waiver Guardrails

CMS has specified four “guardrails” that must be met before a 1332 Waiver can be approved.

The “Evaluation of the Oregon 1332 Waiver Reinsurance Program” report shows that the ORP has met the required guardrails. As noted in that report, the proposed waiver extension will continue to meet the required guardrail conditions:

- The Waiver does not make alterations to the required scope of benefits offered in the insurance market in Oregon and is expected to continue to result in an increase in the number of individuals with coverage that meets the ACA’s Essential Health Benefits requirements as compared to estimates of enrollment without the ORP.
- The Waiver extension will continue to reduce premiums and increase affordability compared to projected non-ORP experience.
- The Waiver extension will continue to cover more individuals in Oregon than would be covered absent the ORP.
- The Waiver extension will continue to result in reduced spending for the federal government compared to projected non-ORP experience.

Based on NovaRest’s analyses, the Oregon proposed extension of the ORP satisfies all four guardrails.

Funding

A portion of the funding for the reinsurance will continue to come from the federal government through a federal pass-through amount due to the reduction in advanced premium tax credits (APTCs) compared to that expected should the ORP end. The reduction in premiums for the second lowest Silver plan directly reduces the APTC for the individuals eligible for APTCs. APTCs are adjusted to final premium tax credits (PTCs) based on income information collected by the IRS at the end of the year. Actual federal savings (and resulting federal pass-through amounts) are calculated from the reduction in PTCs less reductions in federal exchange fee revenues. Estimated federal pass-through funding amounts are developed from NovaRest’s program modeling for the 1332 Waiver extension application. Actual federal funding amounts are based on calculations by the federal government based on review of the projected rate impact of the waiver (from the application), the actual rate filings and the government’s projected enrollment.

In order to secure the required state funding, Oregon will continue to assess a 0.3 percent premium assessment levied on major medical premiums for policies issued in this state and use excess fund balances held in two state programs. Any excess funds will be used by increasing payments to issuers by adjusting the reinsurance parameters.



If the state assessment less administration costs is not sufficient to cover the expected state funding, reinsurance parameters will be adjusted so that available funds less administrative cost will be distributed through the program. This method of setting the assessment will be re-evaluated each year based on modeling of the assessment adequacy. Reinsurance parameters will also be evaluated based on annual projections of claims for the following policy year. For plan year 2023, the reinsurance parameters will be an attachment point of \$95,000, a cap of \$1 million, with a coinsurance of 50%. We used these same parameters for our projections of plan years 2024 to 2027.

Table 1 presents projected assessment total reinsurance, federal funding, and state funding for years 2023 through 2027.

Table 1					
Projected Federal Pass-Through, Oregon Funding and Total Reinsurance					
	2023	2024	2025	2026	2027
Federal Funding	\$54,733,838	\$58,014,787	\$60,564,940	\$63,287,608	\$66,132,596
Oregon Funding	\$58,566,134	\$62,083,184	\$64,817,341	\$67,736,876	\$70,787,989
Total Reinsurance	\$113,299,972	\$120,097,971	\$125,382,281	\$131,024,484	\$136,920,586

In Summary

Under a 1332 Waiver extension, the ORP will continue to reduce premiums and enhance stability in the Oregon individual market.



II. Background

Section 1332 Waiver Extension

CMS permits a state with an approved 1332 Waiver to apply for an a 5-year extension of the Waiver in order to maintain its program(s) to provide residents with more affordable coverage and maintain enhanced market stability/ Guardrails

Section 1332 of the Affordable Care Act (ACA) authorizes states to waive certain requirements of the ACA, under an approved waiver program. The section allows states to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance. States can request a waiver related to benefits, subsidies, the marketplaces, and the individual and employer mandates. In 2012, the Department of Health and Human Services (HHS) issued regulations for Section 1332 Waivers.¹ In 2015, the Department of Treasury and HHS released guidance on how they would interpret the law's guardrail requirements.² On September 27, 2021 the Department of Treasury and HHS released additional guidance providing more flexibility in meeting the Waiver guardrails³ and this 2021 guidance repealed and replaced the 2018 guidance. As of November 2019, sixteen States had received approved waivers: Alaska, Colorado, Delaware, Georgia, Hawaii, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, and Wisconsin.⁴ California, Iowa and Oklahoma filed Waivers but subsequently withdrew their applications. There are a variety of waiver approaches other states have examined. CMS requires that any extension of a 1332 Waiver must continue to meet all guardrails.

According to CMS guidelines, Oregon must demonstrate that the extended waiver meets the four guardrails to be approved. The four guardrails are:

Comprehensive Coverage – 1332(b)(1)(A). The proposed waiver cannot make alterations to the required scope of benefits offered in the Oregon insurance market and cannot result in a decrease in the number of individuals with coverage that meet the ACA's Essential Health Benefits requirements.

Affordability – 1332(b)(1)(B). The proposed waiver cannot decrease existing coverage or cost-sharing protections against excessive out-of-pocket spending. The waiver cannot result in any decrease in affordability for individuals.

¹Application, Review, and Reporting Process for Waivers for State Innovation. Final Rule. Department of Treasury. February 27, 2012. <https://www.govinfo.gov/content/pkg/FR-2012-02-27/pdf/2012-4395.pdf>

² Ibid.

³ State Relief and Empowerment Waivers. Guidance. Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services; Department of the Treasury. September 27, 2021. [2021-20509.pdf \(govinfo.gov\)](https://www.govinfo.gov/content/pkg/FR-2021-09-27/pdf/2021-20509.pdf)

⁴Tracking Section 1332 State Innovation Waivers. Kaiser Family Foundation. November 1, 2020. <https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/>



Scope of Coverage – 1332(b)(1)(C). The proposed waiver must provide coverage to at least a comparable number of residents as would be provided coverage absent the waiver.

Federal Deficit Neutrality – 1332(b)(1)(D). The proposed waiver cannot result in increased spending, administrative, or other expenses to the federal government.

If approved, a state will continue to receive a “pass-through” of federal funds that would have otherwise been applied to premium tax credits had the state not received the waiver.

Actuarial Certification

A 1332 Waiver extension also requires an actuarial certification. The requirements of the actuarial certification have also changed since 2012. The requirements are listed in Appendix C.

Current Environment

Oregon currently operates the ORP under the existing 1332 Waiver effective January 1, 2018 and approved through December 31, 2022. The program has succeeded in reducing premiums, and, thus, increasing affordability of coverage in the Oregon individual market. Information on the current program, including number of issuers, number of plan offerings, premium reductions and enrollment are included in the “Evaluation of the Oregon 1332 Waiver Reinsurance Program” included in the waiver extension application materials.

Extending the reinsurance program will continue to result in lower premiums than those if the extension is not approved, keeping insurance more affordable. The result therefore, should be more individuals staying in the market, which will help maintain stability in the individual health insurance market.



III. Methodology

NovaRest Analysis Process and Assumptions

As a starting point for our projections, NovaRest performed an issuer data call of 2021 incurred claims paid through January 2022 as well as membership and premiums as of January 2022. As of the date of this report, the expanded subsidies under the American Rescue Plan (ARP) will expire at the end of 2022. Thus, our modeling removes the impact of the expanded subsidies beginning in 2023. The current proposed Build Back Better legislation recently passed by the U.S. House of Representatives contains provisions to extend the ARP subsidies through 2025. However, this legislation has not been passed by the U.S. Senate. Should legislation be enacted prior to the date of submission of the Oregon 1332 Waiver extension application, we will revise our projections accordingly.

Data

Issuer Data Call

NovaRest performed a data call regarding the individual ACA market issuers in Oregon, which include: BridgeSpan Kaiser, Moda, PacificSource, Providence, and Regence. The data call requested individual ACA market member-level data which included plan ID, APTC indicator, premium, family indicator, rating area, exchange status, and age as of January 2022. We also collected claims incurred by member in 2021, paid through January 2022.

We also collected rate filing information for all carriers from plan year 2018 to 2022.

Those from 0% of the federal poverty level (FPL) to 138% of the FPL are covered by Medicaid. Members are eligible for APTC up to 400% FPL beginning in 2023 when the ARP expires. Members at the 100% cost-sharing reduction (CSR) level who are eligible for APTC (of which there were 985 according to the data call) were evenly distributed between the 138% to 250% FPL ranges.

Market Projections and Assumptions

Membership Projections

Individuals that were eligible for 100% CSR, 94% CSR, 87% CSR, 73% CSR and APTC non-CSR were determined to be the ones most likely to retain coverage, although many circumstances can arise that result in turnover in this market segment, such as becoming employed by an employer that offers health insurance or moving out of state. Since NovaRest cannot predict employment or what percentage of the population might move out of state, we treated these members as a stable block.



For all other individuals NovaRest used the elasticity by metal level presented at a Society of Actuaries (SOA) training session.⁵ The elasticity estimates the percentage of membership that will reduce coverage (buy-down) based on the percent of rate increase. We assume individuals who buy-down will only reduce by one metal level at a time, i.e. Gold to Silver, Silver to Bronze, Bronze and Catastrophic to uninsured. We assume individuals will maintain their exchange status, so that those who purchase coverage on exchange, when buying-down, would continue to purchase on exchange, except the Silver level where on-exchange premiums are loaded for the federal defunding of CSRs. In this case, a non-subsidized member enrolled at the Gold coverage level on exchange is assumed to buy-down to the Silver level but purchase off-exchange where the premiums are not loaded.

Individuals with Catastrophic coverage may age out or, based on the rate increase, decide to drop coverage and become uninsured. For the loss of membership due to aging, NovaRest used a steady state and decided that new entrants would replace individuals aging out. For the portion of the individuals deciding to drop coverage NovaRest used a Catastrophic specific elasticity.⁶

Premium and Claims Trend

The 2021 incurred claims data we received only included one month of run-out (paid through January 2022). We applied an adjustment for incurred but not reported (IBNR) to 2021 paid claims of 6%. We did not model the IBNR to determine the assumption, but reviewed DCBS claims data which included information on service dates and paid dates for claims incurred in 2020 and paid through June 2021 to inform our assumption.

For 2021 incurred claims, we used the average carrier projected claim trends from the carrier URRTs to trend to 2023. To trend claims as well as APTC and non-APTC premium rates from 2022-2027, National Health Expenditure (NHE) trends were used so the same trend was applied to all metal tiers.⁷ We assumed the second lowest cost Silver plan would trend at the same rate as the other plans at the Silver level. The exact trends used are provided in Appendix A.

⁵ Murawski, Engel, Liner. Session 76 L, Understanding Stakeholder Behavior: Hidden Forces in the U.S. Healthcare System. June 12-14, 2017. <https://www.soa.org/globalassets/assets/files/e-business/pd/events/2017/health-meeting/pd-2017-06-health-session-076.pdf>.

⁶ Ibid.

⁷ NHE Projections 2018-2027. Centers for Medicare and Medicaid Services. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected>.



We also considered the impact of COVID. The carrier's plan year 2022 rate filings showed an impact ranging from -5.5% to 7.0%. The claims requested from the data call were incurred in 2021, and we expect the impact will be reduced from the impact plan year 2020. We compared our estimated 2021 incurred claims to 2019 incurred claims⁸ which showed approximately 4.2% annual increase which is consistent with recent carrier claims trend projections and therefore we did not include any adjustment for COVID.

We considered differences in membership from 2021 to 2023. According to the 3Q2021 quarterly enrollment report provided by DFR, there were 172,345 members in the individual ACA compliant market (including both on-and-off exchange). We compared this to our expectation of total membership in PY 2023 of 174,092,⁹ or about 1% increase. We applied the 1% increase to the expected reinsured claims, as we anticipate the level of claims for these additional members will be consistent with the market, and they would not impact the 2021 paid claims.

We considered the impact of changes in Medicaid eligibility when an end to the public health emergency is announced, which may cause some currently members currently enrolled in Medicaid to enter the Oregon individual ACA-compliant market. We compared the number of members in the Oregon individual ACA-compliant market in 2019 of 177,201¹⁰ to the number of members reported by carriers as of January 2022 which showed 177,739. Because the overall level of enrollment has not changed from prior to the public health emergency, uncertainty of when the public health emergency will end, and potential for members to leave the market as ARP expires at the end of 2022, we did not include any impact.

Carrier's January 2022 premium and membership data included an indicator of APTC members, however, due to the ARP this currently includes members with incomes over 400% FPL. As part of the data call we received monthly aggregate premiums and APTC as of January 2022. We used this to determine the member maximum responsibility and compared that to a person/family at 400% FPL with the current ARP maximum premium responsibility of 8.5% of income. If the member premium calculated from the carrier data was greater than the maximum premium for a person/family at 400% FPL, they were removed from APTC eligibility after 2022 when we assume the ARP will expire, as these members would not be eligible for APTC.

⁸ Carrier 2019 EDGE data

⁹ Please see our report NovaRest Oregon 1332 Waiver Extension Actuarial Report included in the Oregon 1332 Waiver Extension application for more information on our estimate of 2023 Oregon individual ACA-compliant membership.

¹⁰ Section 1332 of the Patient Protection and Affordable Care Act (PPACA)
State Innovation Waivers - Reinsurance Waiver Annual Report. April 24, 2020.
<https://dfir.oregon.gov/business/reg/health/Documents/reinsurance-annual-report-20200430.pdf>



APTC and PTC Projections

From the issuer data call, NovaRest received the aggregate premium rate for individuals and families that are eligible for APTCs. We developed the maximum premium that an individual or family may pay using 2021 IRS guidance on maximum premium as a % of income, assuming the temporary subsidies included in the American Rescue Plan (ARP) will not continue beyond 2022.¹¹

The aggregate premium rate is the premium that the individuals would pay, if they did not receive the APTC, which is the second lowest Silver rate in each region. The tobacco rate charged to smokers was not considered since it is not used in the APTC determination. The second lowest silver plan in Oregon by rating area for plan year 2022 is as follows:

Table 2	
Second Lowest Cost Silver by Rating Area	
Area	Premium PMPM
Rating Area 1	\$319.48
Rating Area 2	\$370.00
Rating Area 3	\$340.32
Rating Area 4	\$378.00
Rating Area 5	\$352.00
Rating Area 6	\$352.00
Rating Area 7	\$395.00

We have assumed a Federal Poverty Level (FPL) increase of 2.4% a year,¹² which we have used to trend the maximum premium that a family will pay. The family FPL in 2022 is \$13,590 for the first person plus \$4,720 for each additional person.¹³ A family of 4 is \$13,590 plus 3 times \$4,720 or \$27,750. The single person FPL rate has been increasing by 1% to 6% annually, but increased 5.5% from 2021 to 2022, and the additional person has been increasing by 1% to 4% annually.¹⁴

An individual’s APTC is the difference between the second lowest cost Silver plan in the region for the individual’s age and the maximum premium for an individual. For a family it is the sum of all of the second lowest cost Silver plans in the region for the individual’s age for each individual and the maximum family premium.

Oregon currently has a 1332 waiver. For the non-waiver scenario, the removal of reinsurance program is expected to increase the second lowest Silver premium, which increases the APTC.

¹¹ 26 CFR 601.105: Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability. Calendar Year 2021. <https://www.irs.gov/pub/irs-drop/rp-20-36.pdf>

¹² The FPL increase is based on a 5-year history of FPL increases.

¹³ “Prior HHS Poverty Guidelines And Federal Register References”. Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

¹⁴ Ibid.



The reinsurance lowers the premiums for all plans, but the second lowest Silver plan is the one that impacts the APTC. NovaRest assumed that the premium reduction was the same percentage for all plans due to the single risk pool requirement.¹⁵ The difference in the premiums for the second lowest Silver plans with and without the reinsurance that PTCs are 95% of APTCs based on recent historic ratios published by the IRS.^{16,17} This is the amount that CMS will save in PTC and that can be applied to the reinsurance funding.

The amount that the federal government can contribute and remain deficit neutral is the savings from the reduced PTCs less the loss of the exchange user fees. Exchange user fees for the individual market for a state-based exchange on the federal platform is 2.25% of premium paid on exchange plans in 2022.¹⁸ Thus, when the premium is reduced, this income to the federal government is also reduced. The amount of federal savings is the reduction in PTC less the exchange user fees. For example, if PTC has a 15% reduction in premiums the net amount of savings to the federal government is 15% less the 2.25%, which is 12.75%.

Non-ACA Business

We assume all enrollees still enrolled in grandfathered plans would keep their grandfathered plans and would not transition into the ACA individual market. Oregon does not have any transitional (“grandmothered”) plans.

Reinsurance

We developed reinsurance parameters such that the total estimated reinsurance amount, and resulting estimated average premium reduction would result in the target state responsibility amounts and estimated federal pass-through funding, while not deviating significantly from the prior amounts. To develop the reinsurance amount from current ACA plans, we applied an IBNR adjustment and trended the claims for each enrolled individual (provided by the issuers) and applied reinsurance parameters to each trended claim. The reinsured claims were then increased to reflect an expected increase in membership from 2021 to 2023 as discussed above.

¹⁵ Rate increases are rarely the same for all plans due to changes such as differences in morbidity that vary between plans and geographic factor changes. It is not possible to predict these types of factors with an appropriate amount of accuracy.

¹⁶ Health Insurance Premium Tax Credit and Cost-Sharing Reductions. Congressional Research Service. Updated February 3, 2022. <https://sgp.fas.org/crs/misc/R44425.pdf> Page 8

¹⁷ Statistics of Income 2019 IRS Individual Income Tax Returns Complete Report, pg 26. Internal Revenue Service. <https://www.irs.gov/pub/irs-pdf/p1304.pdf>

¹⁸ The Centers for Medicare & Medicaid Services. “HHS Notice of Benefit and Payment Parameters for 2022.” Final Rule. January 19, 2021.



2022 Projections

Using carrier data as of January 2022, our 2022 market projections with the waiver are provided in Table 3. Please note these projections reflect the ARP, which we assume will expire at the end of plan year 2022.

Table 3	
2022 Projections (With ARP Enhanced Subsidies)	
Membership Active on Census Date	2022
APTC On Exchange	95,313
Non-APTC (> 400%) On Exchange	41,468
On-Exchange	136,781
Off-Exchange	40,958
Total ACA	177,739
Average Premium PMPM	
APTC Aggregate Premium Rate	619.61
APTC Premium Rate	428.02
Non-APTC Aggregate Premium Rate	528.06
On-Exchange	591.86
Off-Exchange	495.67
Total ACA	569.69
Total Annual Premium	
APTC Aggregate Premium	\$708,686,329
APTC Premium	\$489,548,205
Non-APTC Aggregate Premium Rate	\$262,773,161
On-Exchange	\$971,459,490
Off-Exchange	\$243,619,465
Total ACA	\$1,215,078,954



Our projected 2023 market is presented in Table 4 below, with and without the proposed reinsurance waiver extension. Please note these projections assume the ARP will expire at the end of plan year 2022.

Table 4			
2023 Projection			
Membership Active on Census Date	Without Waiver	With Waiver	% Change (With Waiver / Without Waiver - 1)
APTC On Exchange	84,753	84,753	0%
Non-APTC (> 400%) On Exchange	44,515	49,123	10%
On-Exchange	129,268	133,876	4%
Off-Exchange	38,859	40,146	3%
Total ACA	168,128	174,023	4%
Average Premium PMPM			
APTC Aggregate Premium Rate	\$702.84	\$644.93	-8%
APTC Premium Rate	\$497.77	\$439.86	-12%
Non-APTC (> 400%)	\$651.23	\$598.35	-8%
On-Exchange	\$685.07	\$627.84	-8%
Off-Exchange	\$573.06	\$525.57	-8%
Total ACA	\$659.18	\$604.25	-8%
Total Annual Premium			
APTC Aggregate Premium	\$714,811,458	\$655,916,516	-8%
APTC Premium	\$506,252,297	\$447,357,355	-12%
Non-APTC (> 400%)	\$347,879,279	\$352,713,918	1%
On-Exchange	\$1,062,690,737	\$1,008,630,434	-5%
Off-Exchange	\$267,222,797	\$253,198,179	-5%
Total ACA	\$1,329,913,534	\$1,261,828,613	-5%



IV. Meeting the Section 1332 Waiver Guardrails

This report demonstrates that the four 1332 Waiver guardrails will continue to be met under the Oregon 1332 Waiver extension structure.

Comprehensive Coverage – The proposed Waiver extension does not make alterations to the required scope of benefits offered in the insurance market in Oregon. It will continue to result in a projected higher number of individuals with coverage that meets the ACA’s EHB requirements, compared to projections without the waiver extension.

Affordability – 1332(b)(1)(B)

The Waiver extension will continue to reduce premiums and increase affordability. We estimate the Waiver extension will lower premiums by approximately 8% in 2023 compared to projected premiums without the waiver. The premium decrease can be seen in Table 4 above.

Scope of Coverage – 1332(b)(1)(C)

The proposed Waiver extension is projected to cover more individuals in Oregon than would be covered should the ORP be abolished (without the waiver extension). We anticipate that individuals will drop existing coverage if the reinsurance program is ended and premiums are increased as result. As can be seen in Table 4, we expect approximately 6,000 covered members would drop coverage in 2023 should the extension application not be approved.

Federal Deficit Neutrality – 1332(b)(1)(D)

The proposed Waiver extension will not result in increased spending, administrative, or other expenses to the federal government. This is because there will be no changes made to the ORP under the waiver extension that would cause such increased spending compared to the current waiver program. We have modeled the impact on federal spending should the ORP be ended. Our modeling includes the elimination of the current federal pass-through payments, as well as the impact on APTCs from the projected increased premiums associated with ORP termination.



V. Five-Year Projections

To develop the projections from 2023-2027, we used the process and assumptions described above. The tables below show the membership and premiums for 2023-2027 for both the with waiver and the without-waiver scenario under which the extension is not approved.

Table 5 shows the development of the projected PTC savings, state funding, and total reinsurance for years 2023 through 2027. Tables 6 and 7 contain the 5 year projections with the waiver extension and without the waiver extension. In the most recent published IRS Statistics of Income report (tax year 2019), the majority of households had PTC higher than the APTC.¹⁹ Although more households had PTC higher than APTC, we calculate that the ratio of PTC to APTC as 95%.²⁰ The ratio in prior years varied from year to year, but was relatively close to 95%, and the American Rescue Plan eliminated the requirement for the filing of the form 8962, which reported the actual PTC compared to the APTC, for 2020.²¹ Also, for plan years 2021 and 2022, CMS will not recheck the IRS data.²² Since we anticipate that reconciliation will continue in the future we made the assumption that the PTC would be 95% APTC based on the recent historic pattern reported by the IRS.

¹⁹ Health Insurance Premium Tax Credit and Cost-Sharing Reductions. Congressional Research Service. Updated February 3, 2022. <https://sgp.fas.org/crs/misc/R44425.pdf>
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²⁰ Statistics of Income 2019 IRS Individual Income Tax Returns Complete Report, pg 26. Internal Revenue Service. <https://www.irs.gov/pub/irs-pdf/p1304.pdf>

²¹ [More details about changes for taxpayers who received advance payments of the 2020 Premium Tax Credit | Internal Revenue Service \(irs.gov\)](#)

²² [What does “Failure to File and Reconcile” mean? \(cms.gov\)](#)



Table 5
Deficit Neutrality Projection, 2023-2027

<u>Without Waiver</u>	2023	2024	2025	2026	2027
Avg State 2LCSP	\$588	\$623	\$651	\$680	\$711
APTC Agg Prem	\$714,811,458	\$757,700,146	\$791,038,952	\$826,635,705	\$863,834,311
APTC Max Prem Paid	\$208,559,161	\$213,601,206	\$218,765,146	\$224,053,927	\$229,470,568
Total APTC	\$506,252,297	\$544,098,939	\$572,273,806	\$602,581,777	\$634,363,743
Total PTC	\$480,939,682	\$516,893,992	\$543,660,115	\$572,452,689	\$602,645,556
<u>With Waiver</u>					
Avg State 2LCSP	\$540	\$572	\$597	\$624	\$652
APTC Agg Prem	\$655,916,516	\$695,271,507	\$725,863,453	\$758,527,309	\$792,661,038
APTC Max Prem Paid	\$208,559,161	\$213,601,206	\$218,765,146	\$224,053,927	\$229,470,568
Total APTC	\$447,357,355	\$481,670,301	\$507,098,307	\$534,473,381	\$563,190,470
Total PTC	\$424,989,487	\$457,586,786	\$481,743,392	\$507,749,712	\$535,030,946
PTC Savings	\$55,950,195	\$59,307,207	\$61,916,724	\$64,702,976	\$67,614,610
Exchange fee decrease	\$1,216,357	\$1,292,420	\$1,351,783	\$1,415,368	\$1,482,014
Net Federal Funding	\$54,733,838	\$58,014,787	\$60,564,940	\$63,287,608	\$66,132,596
Oregon Funding	\$58,566,134	\$62,083,184	\$64,817,341	\$67,736,876	\$70,787,989
Total Reinsurance	\$113,299,972	\$120,097,971	\$125,382,281	\$131,024,484	\$136,920,586

Note, Changes in membership are based on an econometric elasticity model. Since the maximum premium for the APTC is based on a set percentage of APTC member income, which we are not expecting will change from 2023-2027, the APTC members share of the premium increase will likely be lower than that of non-APTC members. As the APTC eligibility is tied to the FPL, we assume incomes for APTC members will increase at the same rate as the FPL, which we have assumed is 2.4% based on a historical analysis.²³ Additionally, some members may lose or gain APTC eligibility which we would not be able to predict. For these reasons we do not change the projected membership level in Tables 6 and 7 for APTC members. We acknowledge that there may be changes in membership, but often those leaving are replaced by new members coming in.

²³ The FPL increase is based on a 5-year history of FPL increases.



Table 6
2023-2027 With Waiver

Membership	2023	2024	2025	2026	2027
100% CSR	985	985	985	985	985
94% CSR (138% to 150% FPL)	9,422	9,422	9,422	9,422	9,422
87% CSR (150% to 200% FPL)	17,671	17,671	17,671	17,671	17,671
73% CSR (200% to 250% FPL)	10,288	10,288	10,288	10,288	10,288
APTC Non-CSR (250% to 400% FPL)	46,387	46,387	46,387	46,387	46,387
Total APTC	84,753	84,753	84,753	84,753	84,753
Total Non-APTC	49,123	46,370	44,456	42,574	40,767
Total On-Exchange	133,876	131,123	129,209	127,327	125,520
Off Exchange	40,146	39,369	38,818	38,265	37,719
Total ACA	174,023	170,492	168,027	165,592	163,239
Average Premium PMPM					
APTC Agg Prem	\$644.93	\$683.63	\$713.70	\$745.82	\$779.38
APTC Max Prem	\$205.07	\$210.02	\$215.10	\$220.30	\$225.63
APTC	\$439.86	\$473.60	\$498.60	\$525.52	\$553.76
Non-APTC	\$598.35	\$633.81	\$661.37	\$690.78	\$721.52
Total On-Exchange	\$627.84	\$666.01	\$695.70	\$727.42	\$760.59
Off Exchange	\$525.57	\$557.16	\$581.65	\$607.75	\$634.98
Total ACA	\$604.25	\$640.87	\$669.35	\$699.77	\$731.57
Total Annual Premium					
Total APTC Agg Prem	\$655,916,516	\$695,271,507	\$725,863,453	\$758,527,309	\$792,661,038
Total APTC Max Prem	\$208,559,161	\$213,601,206	\$218,765,146	\$224,053,927	\$229,470,568
Total APTC	\$447,357,355	\$481,670,301	\$507,098,307	\$534,473,381	\$563,190,470
Total Non-APTC	\$352,713,918	\$352,673,650	\$352,820,739	\$352,915,134	\$352,968,923
Total On Exchange	\$1,008,630,434	\$1,047,945,156	\$1,078,684,193	\$1,111,442,443	\$1,145,629,961
Off Exchange	\$253,198,179	\$263,222,415	\$270,944,367	\$279,064,619	\$287,409,539
Total ACA	\$1,261,828,613	\$1,311,167,571	\$1,349,628,560	\$1,390,507,062	\$1,433,039,500
Exchange Fees	\$22,694,185	\$23,578,766	\$24,270,394	\$25,007,455	\$25,776,674



Table 7
2023-2027 Without Waiver

Membership	2023	2024	2025	2026	2027
100% CSR	985	985	985	985	985
94% CSR (138% to 150% FPL)	9,422	9,422	9,422	9,422	9,422
87% CSR (150% to 200% FPL)	17,671	17,671	17,671	17,671	17,671
73% CSR (200% to 250% FPL)	10,288	10,288	10,288	10,288	10,288
APTC Non-CSR (250% to 400% FPL)	46,387	46,387	46,387	46,387	46,387
Total APTC	84,753	84,753	84,753	84,753	84,753
Total Non-APTC	44,515	42,002	40,255	38,539	36,891
Total On-Exchange	129,268	126,755	125,008	123,292	121,644
Off Exchange	38,859	38,137	37,615	37,086	36,559
Total ACA	168,128	164,891	162,624	160,378	158,203
Average Premium PMPM					
APTC Agg Prem	\$702.84	\$745.01	\$777.79	\$812.79	\$849.36
APTC Max Prem	\$205.07	\$210.02	\$215.10	\$220.30	\$225.63
APTC	\$497.77	\$534.98	\$562.69	\$592.49	\$623.74
Non-APTC	\$651.23	\$689.83	\$719.83	\$751.86	\$785.33
Total On-Exchange	\$685.07	\$726.72	\$759.12	\$793.74	\$829.94
Off Exchange	\$573.06	\$607.30	\$633.86	\$662.18	\$691.74
Total ACA	\$659.18	\$699.10	\$730.15	\$763.32	\$798.01
Total Annual Premium					
Total APTC Agg Prem	\$714,811,458	\$757,700,146	\$791,038,952	\$826,635,705	\$863,834,311
Total APTC Max Prem	\$208,559,161	\$213,601,206	\$218,765,146	\$224,053,927	\$229,470,568
Total APTC	\$506,252,297	\$544,098,939	\$572,273,806	\$602,581,777	\$634,363,743
Total Non-APTC	\$347,879,279	\$347,685,897	\$347,724,507	\$347,711,994	\$347,662,931
Total On Exchange	\$1,062,690,737	\$1,105,386,043	\$1,138,763,459	\$1,174,347,699	\$1,211,497,243
Off Exchange	\$267,222,797	\$277,923,759	\$286,112,856	\$294,689,140	\$303,468,700
Total ACA	\$1,329,913,534	\$1,383,309,802	\$1,424,876,315	\$1,469,036,839	\$1,514,965,943
Exchange Fees	\$23,910,542	\$24,871,186	\$25,622,178	\$26,422,823	\$27,258,688



VI. Limitations

There were a number of limitations in the data received and the assumptions used in developing the projections. Even with these limitations, NovaRest believes that the projections included in this report are reasonable and appropriate for decision-making purposes. NovaRest performed sensitivity testing to verify that varying the assumptions used would not significantly change the results. Actual federal funding through reduced PTC will be based on government projected enrollment and filed premiums rather than on NovaRest's or other projections, so the actual federal pass-through funding may vary from that developed in our modeling and included in our projections. Also, actual issuer-developed rates for 2023 may vary from those assumed.

Additional limitations and considerations include:

1. 2021 incurred claims data paid through January 2022 is from a carrier data call. In addition, claims were adjusted by an IBNR assumption of 6%, trended from 2021-2022 using the carrier member weighted projected trends from the PY2022 URRTs, and the using NHE for trends from 2022-2027. These trends are provided in Appendix A.
2. The data that NovaRest used for membership and premium were snap shots as of January 2022. This may vary from actual 2022 results due to migration from/to the market.
3. NovaRest had little information on individuals eligible for 100% CSR (there are 985 based on the data from the issuers). From the data provided NovaRest knows that they are all eligible for APTCs, but not their actual poverty level. NovaRest allocated the 100% CSR to the CSR levels for the non-100% CSR individuals when calculating subsidies.
4. NovaRest assumed that grandfathered plan enrollees would continue to purchase grandfathered coverage, and we have not assumed migration of such enrollees into the ACA market.
5. NovaRest has estimated federal pass-through funding by estimating federal savings achieved through the reduction in estimated PTCs offset by estimated loss of federal revenue. Actual issuer premiums may deviate from that resulting from our projections. Additionally, actual federal calculation of savings may vary from our projections.
6. Carrier's January 2022 premium and membership data included an indicator of APTC members, however, due to the ARP this currently includes members with incomes over 400% FPL. As part of the data call we received monthly aggregate premiums and APTC as of January 2022. We used this to determine the member maximum responsibility and compared that to a person/family at 400% FPL with the current ARP maximum premium responsibility of 8.5% of income. If the member premium calculated from the carrier data was greater than the maximum premium for a person/family at 400% FPL, they were removed from APTC eligibility after 2022 when we assume the ARP will expire, as these members would not be eligible for APTC.



VII. Actuarial Certification

Reliance

In the analysis described in this report, we relied on information provided by DCBS, information published by the Federal government, public sources and information provided by insurers offering coverage in the Individual ACA-compliant market in Oregon in plan year 2022.

We relied upon this information without independent investigation or audit. If information is inaccurate or incomplete, our findings and conclusions may need to be revised. We have reviewed the data for consistency and reasonableness. Where data was inconsistent or unreasonable, we requested clarification.

Subsequent Events

There are no known subsequent events which impact the analyses described in this report or the results presented.

A potential subsequent event would be the continuation of the American Rescue Plan, but at this time the future of the ARP is unknown.

ASOPS

In performing our analyses, NovaRest used sound actuarial judgement and principles, and complied with all current Actuarial Standards of Practice (ASOPs). In particular, we have complied with ASOP 23 Data Quality, and ASOP 41 Actuarial Communication.

Actuarial Certification

I, Donna Novak, President of NovaRest Actuarial Consulting, am the actuary responsible for this report. I am a Member of the Society of Actuaries and the American Academy of Actuaries. I meet the Qualifications Standards to render this opinion.

We are providing this report solely for the use of supporting Oregon's 1332 Waiver extension application. The intended users of this report are Oregon and those federal agencies to which the application is submitted. Distribution of this report to any other parties does not constitute advice from or by us to those parties. The reliance of other parties on any aspect of our work is not authorized by us and is done at the other party's own risk.



We believe the current Oregon waiver and the waiver extension proposal comply with the following requirements:

- The coverage provided under this 1332 Waiver extension is at least as comprehensive as the coverage available should the current 1332 Waiver not be extended.
- The coverage provided under this 1332 Waiver extension is at least as affordable as the coverage available should the current 1332 Waiver not be extended.
- The 1332 Waiver extension will provide coverage to at least a comparable number of residents as would be available should the current 1332 Waiver waiver not be extended.
- The 1332 Waiver extension will not increase the federal deficit.

The actuarial methodologies utilized in order to arrive at our opinion were those that were considered generally accepted within the industry and are consistent with all applicable ASOPs.

If you have any questions, do not hesitate to call Donna at 520-908-7246.

Sincerely,

Donna C. Novak, FCA, ASA, MAAA, MBA



Appendix A – Trend Assumptions

National Health Expenditure Projection Rates

The NHE Projection data splits out spending for Private Insurance into Employer-Sponsored Insurance (ESI) and Direct Purchase.²⁴ Direct Purchase includes coverage purchased through the Marketplace along with other plans such as Medicare supplemental coverage and individually purchased plans. This category seems to be the best fit for projecting individual spending among the NHE data. It has been used for other 1332 Waiver applications such as New Hampshire, North Dakota, and Wisconsin (which were approved by CMS).

We noticed carrier projected trends were different than NHE trends from 2021-2022. Therefore, we decided to trend the claim distribution from 2021-2022 using an annual 4.1% trend, based on carrier projections provided in the Oregon individual ACA market rate filings. We then reverted to the NHE trends for 2023 and beyond. The NHE trends, compared with the trends used are provided in Table 8.

Table 8		
Year	National Health Expenditure Trends (NHE Table 17 Health Spending by Source of Insurance Coverage Spending Direct Purchase)	Trends Used in Analysis
2022	5.9%	4.1%
2023	6.0%	6.0%
2024	6.0%	6.0%
2025	4.4%	4.4%
2026	4.5%	4.5%
2027+	4.5%	4.5%

Our model currently uses January 2022 actual premiums and membership. For 2023 and beyond, premium and claims PMPM amounts are projected forward using the NHE trends.

²⁴ Projected National Health Expenditure Data. Table 17. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected>



Appendix B – Definitions and Abbreviations

Allowed Claims - The maximum amount a plan will pay for a covered health care service.

Advance Premium Tax Credit “APTC” or Premium Tax Credit “PTC” – A tax credit taken by enrollee to lower monthly health insurance payment. The enrollee will estimate yearly income when they apply for coverage in the Health Insurance marketplace. The APTC will be based on the estimate of the income entered.

Centers for Medicare & Medicaid Services “CMS” - The Centers for Medicare & Medicaid Services, CMS, is part of the Department of Health and Human Services (HHS). CMS oversees many federal healthcare programs, including those that involve health information technology such as the meaningful use incentive program for electronic health records (EHR).

Cost Sharing Reduction “CSR” - A discount that lowers the amount an enrollee will have to pay for deductibles, copayments, and coinsurance. In the Health Insurance Marketplace, cost-sharing reductions are often called “extra savings.”

Essential Health Benefits “EHB” - A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors’ services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

Federal Poverty Level “FPL” - A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

Health Insurance Marketplace “Marketplace” or “exchange” <http://www.healthcare.gov> - A shopping and enrollment service for medical insurance created by the Affordable Care Act in 2010. In most states, the federal government runs the Marketplace (sometimes known as the "exchange") for individuals and families.

Metal Level, Metal Plans, or Metal Categories - Plans in the Health Insurance Marketplace are presented in 4 “metal” categories: Bronze, Silver, Gold, and Platinum.

Patient Protection and Affordable Care Act “ACA” or “Affordable Care Act” - United States federal statute enacted by the 111th United States Congress and signed into law by President Barack Obama on March 23, 2010.

Per Member Per Month “PMPM” - Per Member Per Month, or the average cost of services per individual per month.

Premium - A health insurance premium is a monthly fee paid to an insurance company or health plan to provide health coverage.



Appendix C – Actuarial Certifications

The Actuarial Certification must include:

1. *Actuarial analyses and actuarial certifications.* Actuarial analyses and actuarial certifications to support Oregon’s estimates that the proposed waiver extension will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement.
2. *Economic analyses.* Economic analyses to support Oregon’s estimates that the proposed waiver extension will comply with the comprehensive coverage requirement, the affordability requirement, the scope of coverage requirement and the Federal deficit requirement, including:
 - i. A detailed 5-year budget plan that is deficit neutral to the Federal government, as prescribed CMS instruction to Oregon included in the response to the Oregon Letter of Intent to Apply for Waiver Extension, and includes all costs under the waiver, including administrative costs and other costs to the Federal government, if applicable; and
 - ii. A detailed analysis regarding the estimated impact of the waiver extension on health insurance coverage in Oregon, compared to that projected should the extension not be approved..
3. *Data and assumptions.* The data and assumptions used to demonstrate that Oregon’s proposed waiver extension is in compliance with the comprehensive coverage requirement, the affordability requirement, the scope of coverage requirement and the Federal deficit requirement,

Additional supporting information.

- (1) During the Federal review process, the Secretary may request additional supporting information from Oregon via the Secretary of Health and Human Services as needed to address public comments or to address issues that arise in reviewing the application.
- (2) Requests for additional information, and responses to such requests, will be made available to the public in the same manner as information described in § 33.116 (b).



Appendix D – Qualifications

About the Model Team

NovaRest was hired by the DCBS to perform the actuarial and economic analyses required for an application for an extension of the current Oregon 1332 Waiver reinsurance program. The goal was to model the individual health insurance market and to project estimated experience for an extended reinsurance program as well as that anticipated should the ORP end. NovaRest has been helping state insurance regulators meet their regulatory responsibilities since 2002. The 1332 project included three accredited actuaries, and two actuarial students. The core team members have worked on healthcare actuarial and economic analyses and section 1332 waiver projects. In addition to our unique section 1332 experience, we have performed studies to analyze the cost drivers of health insurance and have analyzed the impact of proposed legislation. NovaRest employs some of the most experienced senior actuaries in the industry. The NovaRest actuaries are experts in the Affordable Care Act (ACA), modeling and project management. In addition, NovaRest has experience working on Section 1332 Waiver and reinsurance projects.

Appendix 7

Office of the Secretary of

Shemia Fagan
Secretary of State

Cheryl Myers
Deputy Secretary of State



State

Audits Division

Kip R. Memmott, MA, CGAP, CRMA
Director

255 Capitol St. NE, Suite 500
Salem, OR 97310

503-986-2255

March 25, 2021

Andrew Stolfi, Director
Department of Consumer and Business Services
350 Winter Street NE
Salem, Oregon 97309

Dear Mr. Stolfi:

We have completed audit work of a selected federal program at the Department of Consumer and Business Services (department) for the year ended June 30, 2020.

Assistance Listing Number	Program Name	Audit Amount
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93.423	1332 State Innovation Waivers Program	\$ 96,327,339	This audit work was not a comprehensive audit of your federal program. We performed this federal compliance audit as part of our annual Statewide Single Audit. The Single Audit is a very specific and discrete set of tests to determine compliance with federal funding requirements, and does not conclude on general efficiency, effectiveness, or state-specific compliance issues. The Office of Management and Budget (OMB) Compliance Supplement identifies internal control and compliance requirements for federal programs. Auditors review and test internal controls over compliance for all federal programs selected for audit and perform specific audit procedures only for those compliance requirements that are direct and material to the federal program under audit. For the year ended June 30, 2020, we determined whether the department substantially complied with the following compliance requirements relevant to the federal program under audit.
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Compliance Requirement	General Summary of Audit Procedures Performed
Activities Allowed or Unallowed	Determined whether federal monies were expended only for allowable activities.
Allowable Costs/Cost Principles	Determined whether charges to federal awards were for allowable costs and that indirect costs were appropriately allocated.
Cash Management	Confirmed program costs were paid for before federal reimbursement was requested, or federal cash drawn in advance was for an immediate need, and applicable interest was reported/remitted.
Suspension and Debarment	Verified that contractors were not suspended, debarred, or otherwise excluded from receiving federal funds.

Reporting	Verified the department submitted financial and performance reports to the federal government in accordance with the grant agreement and that those financial reports were supported by the accounting records.
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Internal Control over Compliance

Department management is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the department’s internal control over compliance with the types of requirements that could have a direct and material effect on the major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for the major program and to test and report on internal control over compliance in accordance with Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the department’s internal control over compliance.

A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. *A material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. *A significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Other Deficiencies

We identified the following other matters that are an opportunity to strengthen internal controls but are not considered to be material weaknesses or significant deficiencies in controls over compliance. These other matters do not require a written response from management.

Implement controls for verifying suspension and debarment

Terms and conditions of the federal award require the department to consult the ineligible parties list and ensure organizations under funding consideration are not ineligible. Department management should maintain effective controls over federal awards to provide reasonable assurance of compliance with the terms and conditions. Payments made to ineligible organizations are considered non-compliant and may be required to be paid back to the federal agency.

Department management indicated they consulted the ineligible parties list to verify recipient organizations were not suspended or debarred prior to disbursing funds. However, the department did not retain documentation of the verification results.

We recommend department management implement a written procedure to verify vendors under funding consideration are not ineligible and retain documentation of the verification.

Improve controls over federal financial reporting

Department management should maintain effective controls over federal awards to ensure quarterly reports are complete, accurate, and supported by adequate documentation. Each year the department submits three quarterly reports one annual report. We reviewed all three quarterly reports and found the department did not maintain sufficient supporting documentation. Additionally, we noted that the report data was submitted to the federal reporting website without independent review. We were able to verify that expenditures reported on the quarterly reports in fiscal year 2020 agreed to the accounting records.

We recommend department management retain documentation that is sufficient to support the completeness and accuracy of quarterly federal financial reports. We also recommend quarterly report data be reviewed prior to submission to ensure accuracy.

The purpose of this communication is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this communication is not suitable for any other purpose.

We appreciate your staff's assistance and cooperation during this audit. Should you have any questions, please contact Janet Lowrey or Amy Dale at 503-986-2255.

Sincerely,

Office of the Secretary of State, Audits Division

State of Oregon

cc: Carolina Marquette, Financial Services Manager
Lane Foulger, Accounting Services Manager
Chiqui Flowers, OHIM Division Administrator
Joel Payton, DFR Reinsurance Program Analyst
Michael Campbell, Chief Internal Auditor
Katy Coba, Director, Department of Administrative Services
Rob Hamilton, SARS Manager, Department of Administrative Services



Oregon

Kate Brown, Governor

Department of Consumer and Business Services

350 Winter Street NE
PO Box 14480
Salem, OR 97309-0405

April 7, 2021

Kip R. Memmott, Director
Oregon Audits Division
255 Capitol Street N.E., Suite 500
Salem, Oregon 97310

Dear Mr. Memmott:

We are providing this letter in connection with your audit, for the fiscal year ended June 30, 2020, of the Department of Consumer and Business Services (department) compliance with requirements that could have a material effect on the following major federal financial assistance program:

CFDA
#
93.423

TITLE
1332 State Innovation Waiver Program

Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

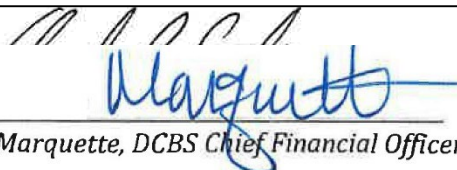
We confirm, as of April 6, 2021, the following representations made to you during your audit:

We are responsible for understanding and complying, and have complied with the requirements of the Uniform Guidance.

1. We are responsible for understanding and complying with the requirements of federal statutes, regulations, and the terms and- conditions of federal awards related to each of our federal programs.
2. We are responsible for establishing and maintaining, and have established and maintained, effective internal controls over compliance for federal programs that provide reasonable assurance that we are managing federal awards in compliance with federal statutes, regulations, and the terms and conditions of the federal award that could have a material effect on our federal programs.
3. We have identified and disclosed all of our government programs and related activities subject to the Uniform Guidance compliance audit

4. We have identified and disclosed to you the requirements of federal statutes, regulations, and the terms and conditions of federal awards that are considered to have a direct and material effect on each federal program.
5. We have made available all federal awards(including amendments, if any) and any other correspondence relevant to federal programs and related activities that have taken place with federal agencies or pass-through entities.
6. There are no known instances of noncompliance with applicable compliance requirements .
7. We believe we have complied with the direct and material compliance requirements.
8. We have made available to you all documentation related to compliance with applicable compliance requirements, including information related to federal program financial reports and claims for advances and reimbursements.
9. Our interpretations of any compliance requirements that have varying interpretations have been provided.
10. We have disclosed to you any communications from federal awarding agencies and pass-through entities concerning possible noncompliance with the direct and material compliance requirements, including communications received from the end of the period covered by the compliance audit to date.
11. We have disclosed to you the findings received and related corrective actions taken for previous audits, attestation engagements, and internal or external monitoring that directly relate to the objectives of the compliance audit, including findings received and corrective actions taken from the end of the audit period covered by the compliance audit to date.
12. We are responsible for taking corrective action on audit findings of the compliance audit and have provided the Department of Administrative Services (DAS) with a corrective action plan that meets the requirements of the Uniform Guidance, which is necessary for DAS to accurately prepare the summary schedule of prior audit findings in accordance with Uniform Guidance.
13. We have provided you with all information on the status of the follow-up on prior audit findings by federal awarding agencies and pass-through entities, including all management decisions.
14. We have disclosed the nature of subsequent events, if any, that provide additional evidence with respect to conditions that existed at the end of the reporting period that affect noncompliance during the reporting period.
15. There are no known instances of noncompliance with applicable compliance requirements subsequent to the period covered by the auditor's report

16. We have disclosed whether any changes in internal control over compliance, or other factors that might significantly affect internal control, including any corrective action taken by management with regard to significant deficiencies and material weaknesses in internal control over compliance, have occurred subsequent to the period covered by the audit report.
17. Federal program financial reports and claims for advances and reimbursements are supported by our books and records from which the statewide financial statements are prepared.
18. Federal program financial reports provided to you are true copies of the reports submitted, or electronically transmitted, to the federal agency or pass-through entity, as applicable.
19. We have charged costs to federal awards in accordance with applicable cost principles.
20. We have no knowledge of any fraud or suspected fraud affecting the department involving (a) management, (b) employees who have significant roles in internal control, or (c) others where the fraud could result in material noncompliance.
21. We have no knowledge of any allegations of fraud or suspected fraud affecting the program communicated by employees, former employees, analysts, regulators or others.
22. We have identified and submitted to DAS, all expenditures of assistance provided by federal agencies for inclusion in the statewide schedule of expenditures of federal awards (SEFA) in accordance with Uniform Guidance, and DAS requirements as stated in the *Oregon Accounting Manual* and the *Year End Closing Manual*. We have included expenditures made during the period being audited for all awards provided by federal agencies in the form of grants, federal cost-reimbursement contracts, loans, loan guarantees, property (including donated surplus property), cooperative agreements, interest subsidies, insurance, food commodities, direct appropriations, and other assistance.
23. We have received no requests from a federal agency to audit one or more specific programs as a major program.



Carolina Marquette, DCBS Chief Financial Officer

Andrew Stolfi, DCBS Director