FAQ's for HB 2391 Premium Assessment

Part I – Applicability of the Premium Assessment

What premiums are subject to the 1.5% premium assessment under HB 2391?

The 1.5% assessment applies to the gross amount of premiums derived from "health benefit plans." The term "health benefit plan" is defined under ORS 743B.005(16). Please note that many categories of health coverage are excluded from the definition of health benefit plan. Premiums derived from those coverages are not health benefits plans and thus are not subject to the assessment.

(16)(a) "Health benefit plan" means any:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or

(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

(H) Short term health insurance policies that are in effect for periods of three months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

Are premiums derived from Accidental Death & Disability (AD&D) policies subject to the assessment?

No. These plans are excluded as "accident only" coverage.

Does the assessment apply to group health plans that are offered to employers and designed to supplement Medicare coverage for retirees?

These policies may be considered "Medicare supplement policies" under Oregon law. Such policies are not considered health benefits plans and are not be subject to the premium assessment.

For purposes of the assessment a Medicare supplement policy is defined under ORS 743.680(4) as:

> *"Medicare supplement policy" means a group or individual policy of insurance or a subscriber contract which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.*

Does the assessment apply to grandfathered plans?

Yes. HB 2391 does not distinguish between grandfathered and non-grandfathered plans. Premiums derived from grandfathered health benefit plans are subject to the assessment unless some other exclusion applies.

Does the assessment apply to policies that renewed in 2017 and are still in effect in 2018?

No. The assessment applies to health benefit plan polices that were issued or renewed on or after January 1, 2018. Policies that were issued or last renewed prior to 2018 are not subject to the HB 2391 assessment until their renewal date in 2018.

Does the assessment apply to premiums derived from policies that were issued in another state but that cover Oregon residents?

No. The assessment applies to the gross amount of premiums derived from health benefit plans that are delivered or issued for delivery in Oregon.

For health benefit plans that are subject to ACA risk adjustment, how should risk adjustment be reflected in the calculation of gross premiums?

Risk adjustment should be excluded from the HB 2391 premium tax calculation.

Part II – Completing the Assessment Report

Who must file a Health Premium Assessment Report in iReg?

All insurers that are authorized to write health insurance in Oregon must file a report. This is the case even if a health insurer doesn't offer any health benefit plans.

My company doesn't offer health benefit plans in Oregon. How should I report?

Companies that had no assessable premiums in the reporting quarter may certify to that fact at the top of the report. Similarly, companies that had no assessable premiums in the reporting quarter and that do not expect to have assessable premiums in future quarters may request a one year exemption. Companies that file under either option do not have to complete the remainder of the report.

My company offers health benefit plans and plans that are not health benefit plans. How should I report?

Report the total health premium at the top of the form. Premiums earned from non-health benefit plans should be reported in the appropriate line and will be deducted from the total. The amount showing in net taxable premiums should equal the total amount of premium derived from health benefit plans.

My company earned premiums from a category of coverage that is not subject to the assessment, but is not shown on the form. How should I report?

Please choose the most appropriate line to report the excluded premium and retain a record of how each type of premium was reported. In the event of an audit, the Division will consider the reasonableness and completeness of your chosen methodology.