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

Nov. 3, 2026

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The Honorable Scott Bessent
Secretary of the Treasury
Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, D.C. 20220

The Honorable Robert F. Kennedy, Jr.
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Nov. 3, 2026

Dear Secretary Bessent and Secretary Kennedy,

The State of Oregon is pleased to submit this application for a five-year extension of Oregon's Section 1332 State Innovation and Empowerment Waiver to continue Oregon's Reinsurance Program (ORP) for the years 2028-32. The state requests 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 Patient Protection and Affordable Care Act is waived through 2027 to allow the state to implement a reinsurance program funded by federal pass-through savings and state funding. We request that Section 1312(c)(1) be waived for an additional five years in order for Oregon to continue operating the reinsurance program.

ORP was successful during our current waiver period (2023-27), helping reduce premiums more than 9.5 percent on average statewide for Oregonians who purchased insurance on the individual market. Access to health insurance is vital for all Oregonians and our health insurance market has remained competitive during the reinsurance program period, with as many as two carriers offering statewide coverage and four carriers offering plans in the state in plan year 2027. Continuing the ORP will help provide greater access to affordable, comprehensive, and high-quality health insurance for Oregon consumers who depend on these valuable resources.

Thank you for considering our application and supporting Oregon's health insurance goals for high-quality health care coverage at affordable prices for Oregonians statewide.

Sincerely,



TK Keen
Oregon Insurance Commissioner and DFR Administrator

Table of Contents

Extension request and reinsurance program overview 2

Oregon's waiver request 2
Oregon Reinsurance Program overview 2
Legislative history of the ORP 2
Oregon Reinsurance Program design 3
Oregon Reinsurance Program performance and parameters 4
Operations going forward 6

Actuarial analysis 2028-32 6

Five-year projections 2028-32 7

Evaluation of guardrails 12

Comprehensive coverage requirement (1332(b)(1)(A)) 12
Affordability requirement (1332(b)(1)(B)) 12
Scope of coverage requirement (1332(b)(1)(C)) 13
Federal deficit requirement (1332(b)(1)(D)) 13

Authority under state law 13

Regulatory oversight 13
Payment parameters rules 13
Oregon Secretary of State 2025 Statewide Single Audit Report 14
SOS DCBS financial audit 14

Public input 14

Public forums 14
Tribal consultation – Oregon DCBS and Oregon Health Authority 14

Conclusion 15

Appendix 1 – House Bill 2010 16

Appendix 2 – Oregon Administrative Rules 836-150-0010 to 0060 40

Appendix 3 – Public Comments 45

Exhibit 2 - AARP 46
Exhibit 3 - PacificSource Health Plans 47
Exhibit 4 – Project Access Now 49
Exhibit 5 – Regence BlueCross BlueShield of Oregon 50
Exhibit 6 – Providence Health Plan 52
Exhibit 7 – Kaiser Permanente 55
Exhibit 8 – Moda Health 56

Appendix 4 – Public Forums 57

Exhibit 9 – Invitation to Nine Federally Recognized Tribes of Oregon 57
Exhibit 10 – SB 770 HHS Cluster Meeting October 6, 2025 58
Exhibit 11 – Pass-through funding 2026 and Waiver extension 63

Appendix 5 – NovaRest actuarial report 74

Appendix 6 – Secretary of State audit 105

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 (Dept. of Treasury, with HHS, collectively "the departments") and to the Centers for Medicare and Medicaid Services, and Center for Consumer Information and Insurance Oversight (CMS/CCIIO). This request seeks to extend the waiver of Section 1312(c)(1) under Section 1332 of the Patient Protection and Affordable Care Act (PPACA/ACA) for a period of five additional years, beginning Jan. 1, 2028, through Dec. 31, 2032.

This waiver extension will not affect any other provision of the ACA and will continue to follow the guardrails set by Section 1332 waiver, as well as principles established by CMS/CCIIO. 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, thereby lowering premiums and reducing federal payment of advance premium tax credits (APTC). Further, the waiver extension will continue to act in accordance with Specific Terms and Conditions set forth by CMS/CCIIO and the departments.

Oregon Reinsurance Program overview

The ORP, created during the 2017 Oregon legislative session, was established to lower the cost of health care premiums and expand health plan options throughout the state. ORP shares the cost of insurance by spreading the risk of high-cost health care claims among all eligible health insurance companies to stabilize Oregon's individual health insurance market.

Since its implementation in 2018, the ORP has been successful in helping insurance companies expand health plan options throughout the state. Currently, six health insurers offer health plan options to Oregon's consumers for the 2026 program year. However, two plan options will exit the individual market for the 2027 program year due to a variety of competitive and business-related decisions. In 2027, in the individual market, two carriers will be available statewide; seven counties will see four choices, 23 counties will see three choices, and six counties will have two choices.[1] The ORP has been identified as one reason Oregon has been able to retain multiple carriers in the market for plan year 2027.

Legislative history of the ORP

Oregon House Bill (HB) 2391 (2017), which established the ORP under DCBS, was signed into law 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 legislation also funded the ORP by a portion of a 1.5 percent premium assessment levied on the

[1] https://dfr.oregon.gov/healthrates/Documents/2027-rate-and-county-coverage.pdf

Public Employees' Benefit Board (PEBB) self-funded plan premium equivalents and major medical insurance policies premiums issued in Oregon. The remaining portion of the assessment is shared with the Oregon Health Authority (OHA) to fund Medicaid.

On March 25, 2019, Oregon HB 2010 extended the state authorization to operate the ORP through Dec. 31, 2027, to coincide with the federal timing if the waiver was extended. DCBS applied for a second five-year waiver in April of 2022. Oregon received an extension of its Section 1332 waiver in 2022 permitting the operation of the ORP through 2027. The bill added stop-loss plans to the premium assessment and also raised the assessment from 1.5 percent to 2.0 percent.

Oregon HB 2010 (2025) (Appendix 1) was signed into law by Oregon Gov. Tina Kotek on March 25, 2025, and it authorizes the ORP to operate through Dec. 31, 2032, to coincide with the current proposed extension of Oregon's Section 1332 waiver.

Oregon Reinsurance Program design

The ORP's purpose is to reduce individual market premiums, incentivize enrollment, and stabilize the individual market. To accomplish this, Oregon's reinsurance program operates like a traditional reinsurance program. The ORP reimburses eligible 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). Informed by actuarial analysis, DCBS sets the program parameters (co-insurance rate, attachment point, and cap) annually through administrative rule.

Eligible health insurance companies on the Oregon Health Insurance Marketplace (OHIM) submit their claims for reimbursement for the benefit year in the following calendar year. DFR financial auditors conduct a detailed audit process to ensure the health care claims that are submitted for reimbursement have been verified pursuant to the Oregon Administrative Rules 836-150-0010 to 836-150-0060 (Appendix 2).

If the audited claims are higher than expected and the authorized budget for that benefit year is not sufficient, DCBS may seek authorization from the Oregon legislature to pay all claims with a combination of both federal and state funding. Alternatively, DCBS may modify the co-insurance rate and decrease reinsurance payments. If future experience is better than expected, Oregon will retain the funds in reserve for payout in future years.

After the audits are completed in the fall of the calendar year following the benefit year, ORP notifies eligible insurers of the reimbursement amounts they are owed and allows for a 30-day appeals process prior to making final payments electronically.

Throughout the waiver period, the ORP submits quarterly and annual reporting[2] to CMS/CCIIO to monitor the program's progress.

[2] Oregon State Innovation Waiver Reinsurance Quarterly Reporting 2018-2026. Division of Financial Regulation : Oregon Reinsurance Program : State of Oregon

Oregon Reinsurance Program performance and parameters

Since 2018, the ORP has reimbursed eligible insurers approximately 50 percent of high-cost health care claims between the attachment point and the $1 million cap.

Table 1 below shows the program parameters, number of eligible insured members who reach the attachment points for a given year, and actual savings due to ORP for the most recent five-year waiver covering the years 2022-25 (2026 is estimated).

Table 1. Program parameters, eligible members, and reimbursements

Years	2022	2023	2024	2025	2026 (estimated)
Eligible insured members	1,952	2,052	2,135	2,172	1,994
Attachment point	$92,000	$95,000	$95,000	$103,000	$108,000
Cap	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Coinsurance rate	48.1%	50%	50%	50%	50%
Reimbursements	$103,763,380.80	$112,036,203.16	$118,442,096.21	$131,042,673.55	$142,700,000
Enrollment	167,369	160,723	164,337	153,417	134,141

For 2027, Oregon set the co-insurance rate at 50 percent for claims between the attachment point at $131,000 and the reinsurance cap at $1 million.

During the first quarter of 2026, approximately 139,804 Oregonians saw their premiums decrease as a result of the reinsurance program.[3] For the past seven years, since the inception of the ORP, enrollment has remained steady based on quarterly reports, although enrollment has declined recently due to changes in the marketplace and the increased cost of premiums for insureds.[4] However, the ORP has sustained a decrease in enrollment to the program due to Oregon's recent establishment of a Basic Health Program (OHP Bridge), which captures consumers formerly enrolled in the individual market who fall within 138 percent to 200 percent of federal poverty level. Even with the OHP Bridge impacts to the individual market for the second quarter of 2026, ORP continues to help over 134,000 members receive more affordable health insurance.

While the ORP has helped stabilize the insurance market and increase choices for consumers, the number of health plan options will reduce in 2027 program year due to increased cost of health insurance, and competitive pressures in the marketplace. Oregonians will have up to four health carrier options[5] for the upcoming 2027 program year (Table 2 and Figure 1). The state is divided into seven geographic areas across 36 counties, with at least two health care carriers offering plans in each zone (Table 2 and Figure 1). Table 2 shows the number of participating carriers by year, as well as the number of plan offerings and the number of silver plan offerings (excluding cost sharing reduction variant plans) on-exchange, off-exchange, and in total. Further, despite the

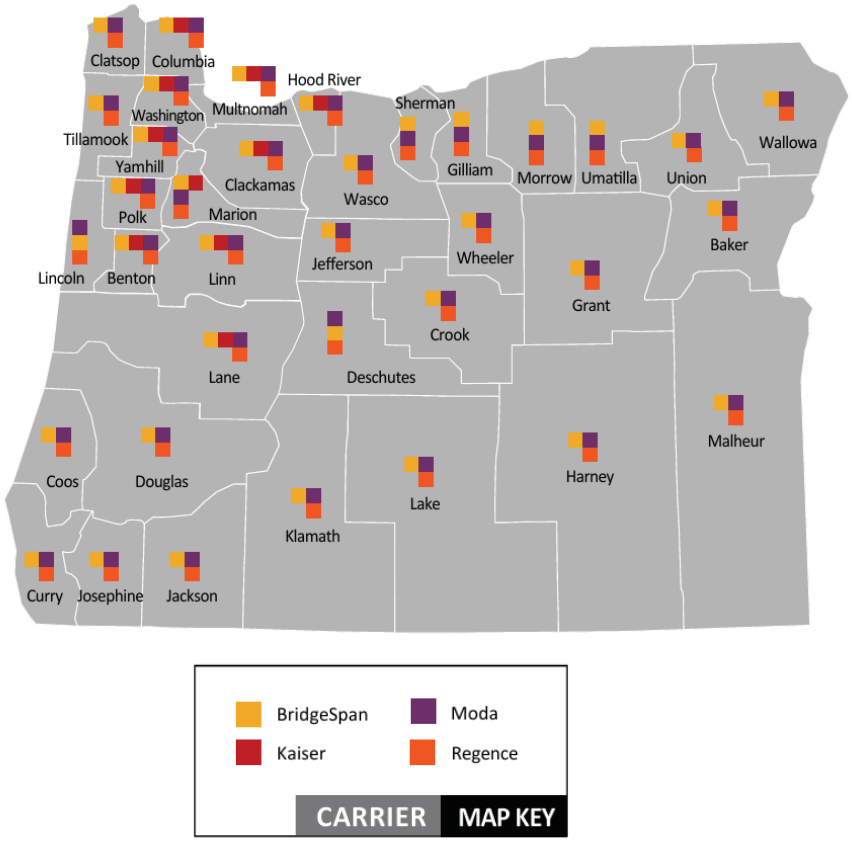
[3] reinsurance-quarterly-report-20260530.pdf
[4] Division of Financial Regulation : Oregon Reinsurance Program : Health insurance regulation : State of Oregon
[5] 2027-rate-and-county-coverage-adjusted.pdf

market changes of the 2027 program year, Oregon's health insurance market remains strong due to the many years of growth and stability afforded by the ORP.

Table 2. Issuers and plan offerings

	Total			On-exchange			Off-exchange - only		
	Issuers	Plans	Silver plans	Issuers	Plans	Silver plans	Issuers	Plans	Silver plans
2023	6	67	25	5	52	17	2	15	8
2024	6	86	31	5	66	21	2	20	10
2025	6	92	31	6	90	29	0	2	2
2026	6	112	53	6	82	27	0	30	26
2027	4	53	24	4	39	11	0	14	13

Figure 1: 2027 individual plan coverage by county in Oregon



In addition, actuarial analysis was completed to estimate the impact of continuing the waiver. As shown in Table 3, actuarial analysis for the current waiver extension period estimates that the reinsurance program will reduce premiums by 9 percent in 2027.

Table 3. 2027 Premium reduction and impact estimate

Description	PMPM
2027 premium per member per month (PMPM) without the program	$798
2027 PMPM with the program	$732
Reduction	-$66.00
Premium impact percentage (-$66.00 ÷ $732.00)	-9.0%

Operations going forward

Oregon's Section 1332 waiver has proven to be a vital resource for these past five years, due to emerging health issues like Covid-19, increasing costs of physician-administered prescription drugs, high-cost health care claims, and increased utilization of care. Even though these issues are impacting Oregon, the ORP has operated consistently with the statutory guardrails of comprehensiveness, affordability, coverage, and federal deficit neutrality. With the waiver and the ORP, Oregon has been able to offer comprehensive health benefit coverage on the Oregon individual health insurance marketplace. As a result of Oregon's successful implementation of the ACA 1332 waiver, Oregon is not requesting changes to our program for this extension application.

Through this waiver extension request, Oregon seeks federal pass-through funds – provided via net premium tax credit savings, estimated to be in excess of $66.9 million per year through 2032 – to partially recoup expected state expenditures (Table 4).

Table 4. Federal Pass – Through Funding				
2028	2029	2030	2031	2032
$66,937,486	$72,048,268	$77,884,178	$84,192,797	$91,012,413

Actuarial analysis 2028-32

The ORP successfully fulfilled the goals outlined in Oregon's 2022 STC guardrails[6] during its second extension from 2023-2027. Approval of Oregon's waiver extension will allow the state to continue providing Oregonians with high quality health insurance coverage at affordable prices.

Actuarial analyses are conducted annually to coincide with current enrollment and approved premium rates on the individual health insurance market. The proposed 1332 waiver extension will continue to improve affordability for Oregon consumers by reducing individual market premiums. According to actuarial analysis, ORP will continue to reduce premiums on average statewide for Oregonians who purchase insurance on the individual market. In fact, actuarial analysis estimates the proposed 1332 waiver extension will reduce average PMPM by approximately 10 percent in each year from 2028 through 2032 compared with costs without the waiver.

To continue administration of the state's reinsurance program, Oregon seeks federal pass-through funds that would have been paid in advance premium tax credits, 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 estimated 9.0 percent in 2027, 10.5 percent in 2028, and 10.5 percent in 2029 through 2032, than they would have been without the waiver and reinsurance program.[7]

[6] https://www.cms.gov/files/document/1332-or-extension-approval-letter-stcs.pdf

[7] APTC is calculated on EHB benefits only, while premium projections reflect a small amount of non-EHB benefits.

Five-year projections 2028-32

To develop the projections for 2028-32, NovaRest Actuarial Consultants provided an evaluation of the Oregon 1332 waiver, with updates to data sources, methodology, and program operations (Appendix 5, Section V). The tables below show the membership and premiums for 2028-32 for both With and Without 1332 Waiver (baseline) scenarios. The assumptions used include movement to the OHP Bridge, with only about 200 OHP Bridge eligible members remaining in the Oregon individual ACA market in 2028, and zero in 2029 and beyond.

Tables 5 and 6 contain the five-year projections (2028-32) for the Without 1332 Waiver scenario and the With 1332 Waiver scenario respectively, while Table 8 provides a comparison of average premium and enrollment. As discussed above, Oregon reassesses the ORP reinsurance parameters annually. For the projections, actuarial analysts did not vary the ORP reinsurance parameters.

Table 5. 2028-32 Without 1332 Waiver (baseline)					
Membership	**2028**	**2029**	**2030**	**2031**	**2032**
100% CSR	750	750	750	750	750
94% CSR	86	0	0	0	0
87% CSR	108	0	0	0	0
73% CSR	8,676	8,676	8,676	8,676	8,676
APTC Non-CSR	44,582	44,550	44,550	44,550	44,550
Total APTC	**54,201**	**53,976**	**53,976**	**53,976**	**53,976**
Total non-APTC	27,404	25,139	23,054	21,135	19,369
Total on-exchange	**81,605**	**79,116**	**77,030**	**75,111**	**73,346**
Off-exchange	28,671	27,810	26,941	26,065	25,185
Total non-group ACA	**110,276**	**106,926**	**103,971**	**101,176**	**98,531**
Average premium PMPM					
APTC agg prem	$1,144	$1,236	$1,336	$1,445	$1,562
APTC net prem	$312	$327	$341	$356	$371
APTC[8]	$829	$907	$992	$1,086	$1,187
Non-APTC	$923	$998	$1,079	$1,167	$1,262
Total on-exchange	$1,070	$1,161	$1,259	$1,366	$1,482
Off-exchange	$957	$1,034	$1,116	$1,206	$1,302
Total non-group ACA	$1,040	$1,128	$1,222	$1,325	$1,436
Total annual premium					
Total APTC agg prem	$743,791,323	$800,682,405	$865,537,679	$935,646,231	$1,011,433,576
Total APTC net prem	$203,141,166	$211,545,632	$220,814,439	$230,489,355	$240,588,175
Total APTC[8]	$539,036,957	$587,400,183	$642,845,987	$703,127,565	$768,651,716
Total non-APTC	$303,632,121	$301,143,642	$298,602,921	$296,000,890	$293,346,227
Total on-exchange	$1,047,423,443	$1,101,826,047	$1,164,140,600	$1,231,647,122	$1,304,779,803
Off-exchange	$329,354,280	$344,999,641	$360,943,479	$377,161,410	$393,630,568
Total non-group ACA	$1,376,777,723	$1,446,825,688	$1,525,084,079	$1,608,808,531	$1,698,410,371

[8] APTC is calculated on EHB benefits only, while premium projections reflect a small amount of non-EHB benefits.

Table 6. 2028-2032 With 1332 Waiver					
Membership	**2028**	**2029**	**2030**	**2031**	**2032**
100% CSR	750	750	750	750	750
94% CSR	86	0	0	0	0
87% CSR	108	0	0	0	0
73% CSR	8,676	8,676	8,676	8,676	8,676
APTC Non-CSR	44,582	44,550	44,550	44,550	44,550
Total APTC	**54,201**	**53,976**	**53,976**	**53,976**	**53,976**
Total non-APTC	32,732	30,064	27,601	25,329	23,236
Total on-exchange	**86,934**	**84,040**	**81,577**	**79,306**	**77,212**
Off-exchange	30,151	29,275	28,396	27,513	26,628
Total non-group ACA	**117,085**	**113,315**	**109,973**	**106,818**	**103,840**
Average premium PMPM					
APTC agg prem	$1,035	$1,119	$1,209	$1,307	$1,413
APTC net prem	$312	$327	$341	$356	$371
APTC[9]	$720	$790	$866	$949	$1,039
Non-APTC	$836	$903	$977	$1,056	$1,142
Total on-exchange	$960	$1,042	$1,131	$1,227	$1,332
Off-exchange	$868	$937	$1,012	$1,093	$1,181
Total non-group ACA	$936	$1,015	$1,100	$1,193	$1,293
Total annual premium					
Total APTC agg prem	$673,189,052	$724,689,542	$783,389,394	$846,843,935	$915,438,294
Total APTC net prem	$203,141,166	$211,545,632	$220,814,439	$230,489,355	$240,588,175
Total APTC[9]	$468,576,445	$511,559,900	$560,862,642	$614,503,569	$672,849,176
Total non-APTC	$328,198,797	$325,856,285	$323,426,921	$320,902,236	$318,293,235
Total on-exchange	$1,001,387,849	$1,050,545,826	$1,106,816,316	$1,167,746,171	$1,233,731,529
Off-exchange	$314,051,865	$329,287,106	$344,924,023	$360,931,867	$377,281,735
Total non-group ACA	$1,315,439,715	$1,379,832,932	$1,451,740,339	$1,528,678,038	$1,611,013,264

[9] APTC is calculated on EHB benefits only, while premium projections reflect a small amount of non-EHB benefits.

Table 7 shows a five-year (2028-32) projection of non-group membership and non-group average premiums which demonstrate that we expect approximately 6 percent higher enrollment and 10 percent lower average premiums PMPM for the With 1332 Waiver scenario compared to Without 1332 Waiver.

Table 7. 2028-32 total non-group ACA enrollment and average premium PMPM					
Membership	**2028**	**2029**	**2030**	**2031**	**2032**
Total non-group ACA without 1332 Waiver (baseline)	110,276	106,926	103,971	101,176	98,531
Total non-group ACA with 1332 Waiver	117,085	113,315	109,973	106,818	103,840
Difference from baseline (number)	6,808	6,389	6,002	5,643	5,309
Difference from baseline (%)	6.2%	6.0%	5.8%	5.6%	5.4%
Average premium PMPM					
Total non-group ACA without 1332 Waiver (baseline)	$1,040	$1,128	$1,222	$1,325	$1,436
Total non-group ACA with 1332 Waiver	$936	$1,015	$1,100	$1,193	$1,293
Difference from baseline (number)	-$104	-$113	-$122	-$133	-$144
Difference from baseline (%)	-10%	-10%	-10%	-10%	-10%

Table 8 provides the statewide average second lowest cost silver plan (SLCSP) at age 21, for the Without 1332 Waiver scenario and the With 1332 Waiver scenario. The statewide average SLCSP is the age 21 SLCSP by rating area, weighted by enrollment in each rating area.

Table 8. 2028-32 age 21 state average SLCSP					
Age 21 state average SLCSP	**2028**	**2029**	**2030**	**2031**	**2032**
Total non-group ACA without 1332 Waiver (baseline)	$595	$643	$695	$752	$812
Total non-group ACA with 1332 Waiver	$538	$582	$629	$680	$735
Difference from baseline (number)	-$56	-$61	-$66	-$71	-$77
Difference from baseline (%)	-9.5%	-9.5%	-9.5%	-9.5%	-9.5%

Table 9 shows the development of the projected PTC savings, Oregon funding, and total ORP reinsurance dollars for years 2028-32. Consistent with Oregon's 2022 actuarial analysis, PTC is estimated as 95 percent of APTCs based on recent historic ratios published by the IRS.[10,11]

Table 9. Budget neutrality projection, 2028-32

Without 1332 Waiver (baseline)	**2028**	**2029**	**2030**	**2031**	**2032**
APTC agg prem	$743,791,323	$800,682,405	$865,537,679	$935,646,231	$1,011,433,576
APTC agg prem (EHB only)	$742,178,123	$798,945,815	$863,660,426	$933,616,920	$1,009,239,891
APTC net prem	$203,141,166	$211,545,632	$220,814,439	$230,489,355	$240,588,175
Total APTC	$539,036,957	$587,400,183	$642,845,987	$703,127,565	$768,651,716
Total PTC	$512,085,109	$558,030,173	$610,703,688	$667,971,187	$730,219,130
With 1332 Waiver					
APTC agg prem	$673,189,052	$724,689,542	$783,389,394	$846,843,935	$915,438,294
APTC agg prem (EHB only)	$671,717,612	$723,105,532	$781,677,080	$844,992,924	$913,437,351
APTC net prem	$203,141,166	$211,545,632	$220,814,439	$230,489,355	$240,588,175
Total APTC	$468,576,445	$511,559,900	$560,862,642	$614,503,569	$672,849,176
Total PTC	$445,147,623	$485,981,905	$532,819,510	$583,778,390	$639,206,717
PTC savings (federal pass-through)	$66,937,486	$72,048,268	$77,884,178	$84,192,797	$91,012,413
Oregon funding	$78,607,716	$86,652,838	$95,816,929	$104,508,310	$112,688,694
Total reinsurance	$145,545,202	$158,701,107	$173,701,107	$188,701,107	$203,701,107

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 claims 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.

[10] Health Insurance Premium Tax Credit and Cost-Sharing Reductions. Congressional Research Service. Updated February 19, 2026. https://www.congress.gov/crs_external_products/R/PDF/R44425/R44425.32.pdf

[11] Statistics of Income 2022 IRS Individual Income Tax Returns Complete Report, Figure G. Internal Revenue Service. https://www.irs.gov/pub/irs-pdf/p1304.pdf. The PTC as a % of APTC varied from 97% in 2021 to 88% in 2022. Therefore, we did not change the assumption of 95% from the prior extension application.

In order to secure the required state funding, Oregon will continue to use 0.5 percent from the 2.0 percent premium assessments. Because the amount of APTC available for eligible consumers is tied to the SLCSP available through OHIM, the amount the federal government will be required to pay in APTC will be reduced. For this waiver request, Oregon seeks the amount of federal savings from these reduced APTC payments (Table 9a), net of other costs that result from the waiver and the ORP. Oregon seeks these funds to offset some of the costs associated with the reinsurance program.

Table 9a. Budget neutrality projection, 2028-32					
	2028	**2029**	**2030**	**2031**	**2032**
PTC savings	$66,937,486	$72,048,268	$77,884,178	$84,192,797	$91,012,413
State funding	$78,607,716	$86,652,838	$95,816,929	$104,508,310	$112,688,694
Total reinsurance	**$145,545,202**	**$158,701,107**	**$173,701,107**	**$188,701,107**	**$203,701,107**
Estimated savings	**10.5%**	**10.5%**	**10.5%**	**10.5%**	**10.5%**

Evaluation of guardrails

The waiver of Section 1312(c)(1) will not negatively impact any of the guardrails as shown in Table 10 and evaluated in more detail for each guardrail within this section.

Table 10. Section 1332 guardrails	
Guardrail	**Effects of waiver**
Comprehensive coverage	No change in EHBs
Affordability	Statewide average premium decrease of 10.5%
Scope of coverage	Sustainable enrollment; 7 zones at least 2 carriers
Federal deficit neutrality	Estimated savings of $392,075,142 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 markets. 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 previously, 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. Although

employer health plans will have a 0.5 percent 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.

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 by approximately 10.5 percent. 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. Two carriers are available in the individual market statewide in plan year 2027. Seven counties will see four choices, 23 counties will see three choices, and six counties will have two choices in 2027 (Table 2 and Figure 1 above). All Oregon ACA-compliant plans continue to be required to provide coverage of essential health benefits, which has not changed under the waiver.

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

As stated above, with the waiver and Oregon's reinsurance program, Oregon anticipates that individual premiums, including premiums for the SLCSP, will be lower, net of the premium assessment. Actuarial analysis projects premium 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 SLCSP, with these lower premiums, the federal government will pay less in APTC. As Table 9a above demonstrates, the federal government will save $392 million over the coming five-year budget cycle (2028-32).

Authority under state law

Regulatory oversight

On March 15, 2025, Oregon HB 2010 (2025) was signed into law by Gov. Kotek, amending HB 2010 (2019) to authorize the ORP through Dec. 31, 2032 to coincide with an extension of Oregon's Section 1332 waiver. Oregon's bipartisan legislation authorized DCBS to apply for an extension of ACA Section 1332 waiver from CMS to implement the ORP for the next five years from Jan. 1, 2028 through Dec. 31, 2032. The governor has pledged to support the ORP for as long as the ACA 1332 State Innovation and Empowerment Waiver exists (Appendix 3).

Payment parameters rules

The Oregon Division of Financial Regulation (DFR), which is part of DCBS, conducts rulemaking to determine and set the reinsurance payment parameters (Appendix 2) by March 30 annually. DFR hosts a public rulemaking advisory committee, comprised of stakeholders from the insurance industry, to discuss the parameters recommended through actuarial analysis and consider stakeholder feedback. After this process, DFR conducts a public hearing on the proposed reinsurance payment parameters. After the public comment period

closes, the rulemaking is finalized.

Oregon Secretary of State 2025 Statewide Single Audit Report

In March 2026 the Oregon Secretary of State Audits Division (SOS) published the Statewide Single Audit Report for the 2025 fiscal year.[12] The audit had no findings related to the financial management or administration of the ORP thus no actions or follow-ups were needed by the program. The audit did have a finding related to the DCBS accounting department's practices around recording financial transactions and corrective action was taken (Appendix 6).

SOS DCBS financial audit

On July 22, 2026, the SOS conducted a routine 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 2025 program year. The SOS audit determination is still pending as of Oct. 1, 2026. State auditors have estimated a completion date before the end of December 2026. When the audit is finalized and published, the ORP will include the audit in the program's subsequent quarterly report.

Public input

Public forums

On July 10, 2026, DCBS held a public forum to inform the general public of the current status of the ORP, pass-through funding for 2026, and our intent to extend the program (Appendix 4, Exhibit 11). The public forum was held virtually and requested public comment on this waiver extension. DCBS also posted a notice to comment on the ORP website at Division of Financial Regulation : Oregon Reinsurance Program : Health insurance regulation : State of Oregon. Additionally, DCBS sent notices via email to its list of interested parties and stakeholders in the first quarter of 2026. As a result, DCBS received written public comments on this waiver extension request (Appendix 3).

On Oct. 9, 2026, ORP conducted a public forum to review the draft of Oregon's 1332 waiver application and give Oregonians the ability to comment on the waiver application before the completed application is submitted to CMS and the departments. Oregon opened a three-week comment period for consumers to respond during which the draft application and recorded webinar were available, ending Oct. 28, 2026.

Tribal consultation – Oregon DCBS and Oregon Health Authority

On Oct. 6, 2025, the director of DCBS, Oregon insurance commissioner, and representatives from the ORP attended the Senate Bill (SB) 770 Oregon Health and Human Services Tribal Cluster meeting virtually and in person in Coos Bay, Oregon, at the Coquille Indian Tribe's Ko-Kwel Wellness Center. This meeting was chaired by the OHA's tribal liaison. At this meeting DCBS announced its intent to extend the Oregon PPACA 1332 Waiver and distributed a slide presentation (Appendix 4, Exhibit 10) describing the functions of the 1332 Waiver and how ORP benefits all who purchase health insurance plans in the individual market. The meeting was comprised of members of the nine federally-recognized tribes in

[12] https://records.sos.state.or.us/ORSOSWebDrawer/Recordhtml/15531589

Oregon, state officials, and stakeholders. Members of all nine tribal governments were in attendance.

Reminders of the PPACA 1332 waiver application were provided by DCBS at each of the SB 770 Oregon Health and Human Services Tribal Cluster meetings, on January 7, 2026, April 1, 2026, and July 1, 2026.

On April 1, 2026, DCBS and OHA sent letters (Appendix 4, Exhibit 9) to the nine federally-recognized tribes of Oregon to ask for permission to confer with each individual governmental leader on health-related concerns that impact their members and how this 1332 waiver could impact their tribe. As of Nov. 3, 2026, no tribe has requested individual government-to-government consultation; the offer to do so remains open.

On Oct. 7, 2026, the deputy director of DCBS and a policy advisor of ORP attended the SB 770 Oregon Health and Human Services Tribal Cluster meeting in Burns, Oregon, hosted by the Burns Paiute Tribe. During this meeting, DCBS provided an update on the 1332 Waiver extension application and an opportunity to ask questions or give feedback. The meeting was comprised of leaders and members of eight of the nine federally-recognized tribes in Oregon, state officials, and stakeholders.

Conclusion

The Oregon Reinsurance Program has been successful during this current waiver period, reducing premiums more than 10.5 percent on average statewide for Oregonians who purchased insurance on the individual market. Access to health insurance remains a key goal and our health insurance market has been stable during the reinsurance program period. The effect of recent market challenges reinforces the need to continue Oregon’s waiver to ensure stability, affordability, access, and comprehensive health plans for Oregonians statewide. Thank you for considering our application and supporting Oregon’s health insurance goals for high-quality insurance at affordable prices.

Appendix 1 – House Bill 2010

Enrolled

House Bill 2010

Sponsored by Representative FAHEY; Representatives GAMBA, TRAN (at the request of Governor Tina Kotek) (Presession filed.)

CHAPTER .....

AN ACT

Relating to funding to improve access to health care; creating new provisions; amending ORS 243.135, 291.055, 317A.100, 414.853, 414.855, 414.871, 414.884, 415.500, 731.292, 731.509 and 731.840 and sections 12, 13 and 14, chapter 736, Oregon Laws 2003, sections 4, 8 and 48, chapter 538, Oregon Laws 2017, and section 19, chapter 2, Oregon Laws 2019; repealing ORS 414.871, 414.880, 414.882, 414.884 and 414.902 and sections 2, 3, 4, 5, 6, 7 and 8, chapter 538, Oregon Laws 2017; and prescribing an effective date.

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

HEALTH INSURANCE PREMIUM ASSESSMENT AND OREGON REINSURANCE PROGRAM

SECTION 1. Section 4, chapter 538, Oregon Laws 2017, as amended by section 5, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 4. Section 3, 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, 2020, through December 31, [*2026*] **2032**.

SECTION 2. Section 8, chapter 538, Oregon Laws 2017, as amended by section 8, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 8. Section 5, chapter 538, Oregon Laws 2017, applies to premiums earned by an insurer for the period beginning January 1, 2020, and ending December 31, [*2026*] **2032**.

SECTION 3. ORS 731.509 is amended to read:

731.509. (1) The purpose of ORS 731.509, 731.510, 731.511, 731.512 and 731.516 is to protect the interests of insureds, claimants, ceding insurers, assuming insurers and the public generally. The Legislative Assembly declares that the intent of the Legislative Assembly is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom insurers and reinsurers owe obligations. In furtherance of that state interest, the Legislative Assembly mandates that upon the insolvency of an alien insurer or reinsurer that provides security to fund the alien insurer's or reinsurer's United States obligations in accordance with ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the assets representing the security must be maintained in the United States and claims must be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets must be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurers. The Legislative Assembly declares that the laws contained

in ORS 731.509, 731.510, 731.511, 731.512 and 731.516 are fundamental to the business of insurance in accordance with 15 U.S.C. 1011 and 1012.

(2) The Director of the Department of Consumer and Business Services may not allow credit for reinsurance to a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded unless credit is allowed as provided under ORS 731.508 and unless the reinsurer meets the requirements of:

(a) Subsection (4) of this section;

(b) Subsection (5) of this section and ORS 731.511 (1);

(c) Subsection (6) of this section;

(d) Subsections (7) and (8) of this section;

(e) ORS 731.511; [*or*]

(f)(A) Subsection (9) of this section; and

(B) Additional requirements that the director specifies by rule, which may include: (i) The valuation of assets or reserve credits;

(ii) The amount and forms of security that support reinsurance arrangements; and (iii) The circumstances under which the director will reduce or eliminate credit[.]**; or**

(g) Subsection (10) of this section.

(3) The director shall allow credit under subsection (4), (5) or (6) of this section or under ORS731.511 only with respect to cessions of the kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in the state in which the assuming insurer is domiciled or, if the assuming insurer is an alien insurer, the state in which the assuming insurer is entered and is licensed or authorized to transact insurance or reinsurance. The director may allow credit under subsection (6) or (7) of this section only if the assuming insurer satisfies applicable requirements under subsection [*(10)*] **(11)** of this section.

(4) The director shall allow credit if the reinsurance is ceded to an authorized assuming insurer that accepts reinsurance of risks and retains the risk of the reinsurance within such limits as the assuming insurer is otherwise authorized to insure in this state, as provided in ORS 731.508.

(5) The director shall allow credit if the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state as provided in ORS 731.511. The director may not allow credit to a domestic ceding insurer if the director has revoked accreditation of the assuming insurer after notice and opportunity for hearing.

(6) The director shall allow credit if the reinsurance is ceded to a foreign assuming insurer ora United States branch of an alien assuming insurer meeting all of the following requirements:

(a) The foreign assuming insurer must be domiciled in a state employing standards regarding credit for reinsurance that equal or exceed the standards applicable under this section. The United States branch of an alien assuming insurer must be entered through a state employing such standards.

(b) The foreign assuming insurer or United States branch of an alien assuming insurer must maintain a combined capital and surplus in an amount not less than $20,000,000. The requirement of this paragraph does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(c) The foreign assuming insurer or United States branch of an alien assuming insurer must submit to the authority of the director to examine the foreign assuming insurer’s or the alien assuming insurer’s books and records.

(7) The director shall allow credit if the reinsurance is ceded to an assuming insurer that maintains a trust fund meeting the requirements of this subsection and subsection (8) of this section and that also complies with other requirements of this subsection and subsection (8) of this section. The trust fund must

be maintained in a qualified United States financial institution, as defined in ORS 731.510 (1), for the payment of the valid claims of the assuming insurer's United States policyholders and ceding insurers and the assigns and successors in interest of the policyholders and ceding insurers. The assuming insurer must report annually to the director information that is substantially the same as information authorized insurers must report on the annual statement form under ORS 731.574, in order to enable the director to determine the sufficiency of the trust fund. The assuming insurer shall submit to the director's examination of the assuming insurer's books and records and shall pay to the director the expenses of the examination.

(8) The following requirements apply to the following categories of assuming insurers:

(a)(A) For a single assuming insurer, the trust fund must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers. In addition, except as provided in subparagraph (B) of this paragraph, the assuming insurer must maintain a trusteed surplus of not less than $20,000,000.

(B) At any time after the assuming insurer permanently discontinues underwriting, for at least three full years, new business that the trust secures, the commissioner that has principal regulatory oversight over the trust may authorize a reduction in the required trusteed surplus, but only after finding based on an assessment of the risk that the new required surplus level is adequate to protect United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and must consider all material risk factors including, if applicable, the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The commissioner may not reduce the amount of the minimum required trusteed surplus below 30 percent of the assuming insurer's liabilities that are attributable to reinsurance that United States ceding insurers covered by the trust have ceded.

(b) For a group that includes incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after August 1, 1995, the trust must consist of a trusteed account in an amount not less than the group's several liabilities attributable to business United States domiciled ceding insurers have ceded to any member of the group.

(B) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the trust must consist of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States.

(C) In addition to the trusts described in subparagraphs (A) and (B) of this paragraph, the group shall maintain in trust a trusteed surplus of which $100,000,000 must be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(D) The incorporated members of the group may not engage in any business other than underwriting as a member of the group and are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(E) Within 90 days after the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if certification is unavailable, financial statements of each underwriter member of the group prepared by independent certified public accountants.

(c) For the group of incorporated insurers described in this paragraph, the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to

any member of the group pursuant to reinsurance contracts issued in the name of the group. This paragraph applies to a group of incorporated insurers under common administration that complies with the annual reporting requirements contained in subsection (7) of this section and that has continuously transacted an insurance business outside the United States for at least three years immediately before applying for accreditation. Such a group must have an aggregate policyholders' surplus of $10,000,000,000 and must submit to the authority of this state to examine the group's books and records and bear the expense of the examination. The group shall also maintain a joint trusteed surplus of which $100,000,000 must be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities. Each member of the group shall make available to the director an annual certification of the member's solvency by the member's domiciliary regulator and the member's independent certified public accountant.

(d) The form of the trust and any amendment to the trust must be approved by the insurance commissioner of the state in which the trust is domiciled or by the insurance commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(e) The form of the trust and any trust amendments also must be filed with the insurance commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to the trust's assets in the trust's trustees for the benefit of the assuming insurer's United States ceding insurers and the assigns and successors in interest of the ceding insurers. The trust and the assuming insurer are subject to examination as determined by the director. The trust must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(f) Not later than March 1 of each year, the trustees of each trust shall report to the director in writing the balance of the trust, list the trust's investments at the preceding year end and certify the date of termination of the trust, if a termination is planned, or certify that the trust will not expire prior to the following December 31.

(9) The director shall allow credit if the reinsurance is ceded to an assuming insurer that does not meet the requirements of subsection (4), (5), (6) or (7) of this section or ORS 731.511 (1) or (4), but only as to the insurance of risks located in jurisdictions in which the reinsurance is required by applicable law or regulation of that jurisdiction.

(10) **The director shall allow credit if the reinsurance is ceded to the Oregon Reinsurance Program established in section 18, chapter 538, Oregon Laws 2017.**

[*(10)*] **(11)** If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this state, the director may not allow the credit permitted by subsections (6) and (7) of this section unless the assuming insurer agrees in the reinsurance agreement to the provisions stated in this subsection. This subsection does not conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate the parties' disputes, if such an obligation is created in the agreement. The assuming insurer must agree in the reinsurance agreement:

(a) That if the assuming insurer fails to perform the assuming insurer's obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(b) To designate the director or a designated attorney as the assuming insurer's true and lawful attorney upon whom any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company may be served.

[*(11)*] **(12)** If the assuming insurer does not meet the requirements of subsection (4), (5) or (6) of this section or ORS 731.511 (1) or (4), the director may not allow the credit permitted by subsection (7) of this section unless the assuming insurer agrees in the trust agreements to the following conditions:

(a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because the trust fund contains an amount less than the applicable amount required by subsection (8)(a), (b) or (c) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of the grantor's state or country of domicile, the trustee shall comply with an order of the insurance commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance commissioner with regulatory oversight all the assets of the trust fund.

(b) The assets must be distributed by and claims must be filed with and valued by the insurance commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that apply to the liquidation of domestic insurance companies.

(c) If the insurance commissioner with regulatory oversight determines that the assets of the trust fund or any part of the assets is not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the insurance commissioner of the state in which the trust is domiciled shall return the assets or part of the assets in accordance with the laws of the state and the terms of the trust agreement that are consistent with the laws of the state.

(d) The grantor shall waive any right otherwise available to the grantor under United States law that is inconsistent with this subsection.

SECTION 4. ORS 731.509, as amended by section 3 of this 2025 Act, is amended to read:

731.509. (1) The purpose of ORS 731.509, 731.510, 731.511, 731.512 and 731.516 is to protect the interests of insureds, claimants, ceding insurers, assuming insurers and the public generally. The Legislative Assembly declares that the intent of the Legislative Assembly is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom insurers and reinsurers owe obligations. In furtherance of that state interest, the Legislative Assembly mandates that upon the insolvency of an alien insurer or reinsurer that provides security to fund the alien insurer's or reinsurer's United States obligations in accordance with ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the assets representing the security must be maintained in the United States and claims must be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets must be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurers. The Legislative Assembly declares that the laws contained in ORS 731.509, 731.510, 731.511, 731.512 and 731.516 are fundamental to the business of insurance in accordance with 15 U.S.C. 1011 and 1012.

(2) The Director of the Department of Consumer and Business Services may not allow credit for reinsurance to a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded unless credit is allowed as provided under ORS 731.508 and unless the reinsurer meets the requirements of:

(a) Subsection (4) of this section;

(b) Subsection (5) of this section and ORS 731.511 (1);

(c) Subsection (6) of this section;

(d) Subsections (7) and (8) of this section;

(e) ORS 731.511; **or**

(f)(A) Subsection (9) of this section; and

(B) Additional requirements that the director specifies by rule, which may include: (i) The valuation of assets or reserve credits;
(ii) The amount and forms of security that support reinsurance arrangements; and (iii) The circumstances under which the director will reduce or eliminate credit[*; or*]
[*(g) Subsection (10) of this section*].

(3) The director shall allow credit under subsection (4), (5) or (6) of this section or under ORS731.511 only with respect to cessions of the kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in the state in which the assuming insurer is domiciled or, if the assuming insurer is an alien insurer, the state in which the assuming insurer is entered and is licensed or authorized to transact insurance or reinsurance. The director may allow credit under subsection (6) or (7) of this section only if the assuming insurer satisfies applicable requirements under subsection [*(11)*] **(10)** of this section.

(4) The director shall allow credit if the reinsurance is ceded to an authorized assuming insurer that accepts reinsurance of risks and retains the risk of the reinsurance within such limits as the assuming insurer is otherwise authorized to insure in this state, as provided in ORS 731.508.

(5) The director shall allow credit if the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state as provided in ORS 731.511. The director may not allow credit to a domestic ceding insurer if the director has revoked accreditation of the assuming insurer after notice and opportunity for hearing.

(6) The director shall allow credit if the reinsurance is ceded to a foreign assuming insurer ora United States branch of an alien assuming insurer meeting all of the following requirements:

(a) The foreign assuming insurer must be domiciled in a state employing standards regarding credit for reinsurance that equal or exceed the standards applicable under this section. The United States branch of an alien assuming insurer must be entered through a state employing such standards.

(b) The foreign assuming insurer or United States branch of an alien assuming insurer must maintain a combined capital and surplus in an amount not less than $20,000,000. The requirement of this paragraph does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(c) The foreign assuming insurer or United States branch of an alien assuming insurer must submit to the authority of the director to examine the foreign assuming insurer's or the alien assuming insurer's books and records.

(7) The director shall allow credit if the reinsurance is ceded to an assuming insurer that maintains a trust fund meeting the requirements of this subsection and subsection (8) of this section and that also complies with other requirements of this subsection and subsection (8) of this section. The trust fund must be maintained in a qualified United States financial institution, as defined in ORS 731.510 (1), for the payment of the valid claims of the assuming insurer's United States policyholders and ceding insurers and the assigns and successors in interest of the policyholders and ceding insurers. The assuming insurer must report annually to the director information that is substantially the same as information authorized insurers must report on the annual statement form under ORS 731.574, in order to enable the director to determine the sufficiency of the trust fund. The assuming insurer shall submit to the director's examination of the assuming insurer's books and records and shall pay to the director the expenses of the examination.

(8) The following requirements apply to the following categories of assuming insurers:
(a)(A) For a single assuming insurer, the trust fund must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers.

In addition, except as provided in subparagraph (B) of this paragraph, the assuming insurer must maintain a trusteed surplus of not less than $20,000,000.

(B) At any time after the assuming insurer permanently discontinues underwriting, for at least three full years, new business that the trust secures, the commissioner that has principal regulatory oversight over the trust may authorize a reduction in the required trusteed surplus, but only after finding based on an assessment of the risk that the new required surplus level is adequate to protect United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and must consider all material risk factors including, if applicable, the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The commissioner may not reduce the amount of the minimum required trusteed surplus below 30 percent of the assuming insurer's liabilities that are attributable to reinsurance that United States ceding insurers covered by the trust have ceded.

(b) For a group that includes incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after August 1, 1995, the trust must consist of a trusteed account in an amount not less than the group's several liabilities attributable to business United States domiciled ceding insurers have ceded to any member of the group.

(B) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the trust must consist of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States.

(C) In addition to the trusts described in subparagraphs (A) and (B) of this paragraph, the group shall maintain in trust a trusteed surplus of which $100,000,000 must be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(D) The incorporated members of the group may not engage in any business other than underwriting as a member of the group and are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(E) Within 90 days after the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if certification is unavailable, financial statements of each underwriter member of the group prepared by independent certified public accountants.

(c) For the group of incorporated insurers described in this paragraph, the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group. This paragraph applies to a group of incorporated insurers under common administration that complies with the annual reporting requirements contained in subsection (7) of this section and that has continuously transacted an insurance business outside the United States for at least three years immediately before applying for accreditation. Such a group must have an aggregate policyholders' surplus of $10,000,000,000 and must submit to the authority of this state to examine the group's books and records and bear the expense of the examination. The group shall also maintain a joint trusteed surplus of which $100,000,000 must be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities. Each member of the group shall make available to the

director an annual certification of the member's solvency by the member's domiciliary regulator and the member's independent certified public accountant.

(d) The form of the trust and any amendment to the trust must be approved by the insurance commissioner of the state in which the trust is domiciled or by the insurance commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(e) The form of the trust and any trust amendments also must be filed with the insurance commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to the trust's assets in the trust's trustees for the benefit of the assuming insurer's United States ceding insurers and the assigns and successors in interest of the ceding insurers. The trust and the assuming insurer are subject to examination as determined by the director. The trust must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(f) Not later than March 1 of each year, the trustees of each trust shall report to the director in writing the balance of the trust, list the trust's investments at the preceding year end and certify the date of termination of the trust, if a termination is planned, or certify that the trust will not expire prior to the following December 31.

(9) The director shall allow credit if the reinsurance is ceded to an assuming insurer that does not meet the requirements of subsection (4), (5), (6) or (7) of this section or ORS 731.511 (1) or (4), but only as to the insurance of risks located in jurisdictions in which the reinsurance is required by applicable law or regulation of that jurisdiction.

[*(10) The director shall allow credit if the reinsurance is ceded to the Oregon Reinsurance Program established in section 18, chapter 538, Oregon Laws 2017.*]

[*(11)*] **(10)** If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this state, the director may not allow the credit permitted by subsections (6) and (7) of this section unless the assuming insurer agrees in the reinsurance agreement to the provisions stated in this subsection. This subsection does not conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate the parties' disputes, if such an obligation is created in the agreement. The assuming insurer must agree in the reinsurance agreement:

(a) That if the assuming insurer fails to perform the assuming insurer's obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(b) To designate the director or a designated attorney as the assuming insurer's true and lawful attorney upon whom any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company may be served.

[*(12)*] **(11)** If the assuming insurer does not meet the requirements of subsection (4), (5) or (6) of this section or ORS 731.511 (1) or (4), the director may not allow the credit permitted by subsection (7) of this section unless the assuming insurer agrees in the trust agreements to the following conditions:

(a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because the trust fund contains an amount less than the applicable amount required by subsection (8)(a), (b) or (c) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of the grantor's state or country of domicile, the trustee shall comply with an order of the insurance commissioner with regulatory

oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance commissioner with regulatory oversight all the assets of the trust fund.

(b) The assets must be distributed by and claims must be filed with and valued by the insurance commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that apply to the liquidation of domestic insurance companies.

(c) If the insurance commissioner with regulatory oversight determines that the assets of the trust fund or any part of the assets is not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the insurance commissioner of the state in which the trust is domiciled shall return the assets or part of the assets in accordance with the laws of the state and the terms of the trust agreement that are consistent with the laws of the state.

(d) The grantor shall waive any right otherwise available to the grantor under United States law that is inconsistent with this subsection.

SECTION 5. Section 48, chapter 538, Oregon Laws 2017, as amended by section 3, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 48. Sections 18 to 22, chapter 538, Oregon Laws 2017, are repealed on January 2, [*2028*] **2038**.

SECTION 6. (1) Section 2, chapter 538, Oregon Laws 2017, is repealed on January 2, 2038.

(2) Section 3, chapter 538, Oregon Laws 2017, as amended by section 4, chapter 2, Oregon Laws 2019, is repealed on January 2, 2038.

(3) Section 4, chapter 538, Oregon Laws 2017, as amended by section 5, chapter 2, Oregon Laws 2019, and section 1 of this 2025 Act, is repealed on January 2, 2038.

(4) Section 5, chapter 538, Oregon Laws 2017, as amended by section 6, chapter 2, Oregon Laws 2019, is repealed on January 2, 2038.

(5) Section 6, chapter 538, Oregon Laws 2017, as amended by section 7, chapter 2, Oregon Laws 2019, is repealed on January 2, 2038.

(6) Section 7, chapter 538, Oregon Laws 2017, is repealed on January 2, 2038.

(7) Section 8, chapter 538, Oregon Laws 2017, as amended by section 8, chapter 2, Oregon Laws 2019, and section 2 of this 2025 Act, is repealed on January 2, 2038.

SECTION 7. Nothing in the repeal of sections 2 to 8, chapter 538, Oregon Laws 2017, by section 6 of this 2025 Act affects the imposition and collection of a health insurance premium assessment under section 3 or 5, chapter 538, Oregon Laws 2017, for a calendar quarter ending on or before December 31, 2032.

SECTION 8. Any moneys remaining in the Health System Fund established by section 2, chapter 538, Oregon Laws 2017, on December 31, 2038, are transferred to the General Fund.

MANAGED CARE ORGANIZATION ASSESSMENT

SECTION 9. ORS 414.884 is amended to read:

414.884. ORS 414.880, 414.882 and 414.902 apply to any payments made to a managed care organization by the Oregon Health Authority for the period beginning January 1, 2020, and ending December 31, [*2026*] **2032**.

SECTION 10. ORS 414.880, 414.882, 414.884 and 414.902 are repealed on January 2, 2038.

SECTION 11. Nothing in the repeal of ORS 414.880, 414.882, 414.884 and 414.902 by section 10 of this 2025 Act affects the imposition and collection of a managed care organization assessment under ORS 414.880 for a calendar quarter ending on or before December 31, 2032.

HOSPITAL ASSESSMENT

SECTION 11a. ORS 414.853 is amended to read:

414.853. As used in ORS 414.853 to 414.869 and 414.900:

(1) "Charity care" means costs for providing inpatient or outpatient care services free of charge or at a reduced charge because of the indigence or lack of health insurance of the patient receiving the care services.

(2) "Contractual adjustments" means the difference between the amounts charged based on the hospital's full established charges and the amount received or due from the payor.

(3)(a) "Hospital" means a hospital licensed under ORS chapter 441.

(b) "Hospital" does not include:

(A) Special inpatient care facilities;

(B) Hospitals that provide only psychiatric care;

(C) Pediatric specialty hospitals providing care to children at no charge; and

(D) Public hospitals other than hospitals created by health districts under ORS 440.315 to440.410.

(4) "Net **inpatient** revenue":

(a) Means the total amount of charges for inpatient [*or outpatient*] care provided by the hospital to patients, less charity care, bad debts and contractual adjustments;

(b) Does not include revenue derived from sources other than inpatient [*or outpatient*] operations, including but not limited to interest and guest meals; and

(c) Does not include any revenue that is taken into account in computing a long term care facility assessment under ORS 409.800 to 409.816 and 409.900.

(5) "Net outpatient revenue":

(a) Means the total amount of charges for outpatient care provided by the hospital to patients, less charity care, bad debts and contractual adjustments;

(b) Does not include revenue derived from sources other than outpatient operations, including but not limited to interest and guest meals; and

(c) Does not include any revenue that is taken into account in computing a long term care facility assessment under ORS 409.800 to 409.816 and 409.900.

[*(5)*] **(6)** "Type A hospital" has the meaning given that term in ORS 442.470.

[*(6)*] **(7)** "Type B hospital" has the meaning given that term in ORS 442.470.

SECTION 11b. ORS 414.855 is amended to read:

414.855. (1) An assessment is imposed on the net **inpatient** revenue **and net outpatient revenue** of each hospital in this state. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate needed to fund the services and costs identified in ORS 414.869. The rate of assessment shall be imposed on the net **inpatient** revenue **and net outpatient revenue** of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

(2) Each assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the 45th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection (5) of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

(3)(a) To the extent permitted by federal law, aggregate assessments imposed under this section may not exceed the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

(A) 30 percent of payments made to the hospitals on a fee-for-service basis by the authority for inpatient hospital services;

(B) 41 percent of payments made to the hospitals on a fee-for-service basis by the authority for outpatient hospital services; and

(C) Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.570 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed under this section on or after July 1, 2015, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for hospital services under ORS 414.591, 414.631 and 414.688 to 414.745.

(c) The director may impose a lower rate of assessment on type A hospitals and type B hospitals to take into account the hospitals' financial position.

(d) **The director may adopt different rates of assessment for net inpatient revenue and net outpatient revenue.**

(4) Notwithstanding subsection (3) of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

(5)(a) The authority shall develop a schedule for collection of the assessment for [*the*] **each** calendar quarter [*ending September 30, 2021, that will result in the collection occurring between December 15, 2021, and the time all Medicaid cost settlements are finalized for that calendar quarter*].

(b) The authority shall prescribe by rule criteria for late payment of assessments.

SECTION 11c. ORS 414.871 is amended to read:

414.871. ORS 414.853 to 414.869 and 414.900 apply to net **inpatient** revenues **and net outpatient revenues** earned by hospitals during a period beginning July 1, 2019, and ending the earlier of [*September 30, 2025*] **December 31, 2032**, 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 12. 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, section 38, chapter 538, Oregon Laws 2017, and section 14, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 12. (1) [*Sections 1 to 9, chapter 736, Oregon Laws 2003,*] **ORS 414.853, 414.855, 414.857, 414.863, 414.865, 414.867, 414.869 and 414.900 and section 4, chapter 736, Oregon Laws 2003,** are repealed on January 2, [*2031*] **2038**.

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

SECTION 13. ORS 414.871 is repealed on January 2, 2038.

SECTION 14. 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, section 39, chapter 538, Oregon Laws 2017, and section 15, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 13. Nothing in the repeal of [*sections 1 to 9, chapter 736, Oregon Laws 2003,*] **ORS 414.853, 414.855, 414.857, 414.863, 414.865, 414.867, 414.869 and 414.900 and section 4, 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,*] **ORS 414.853, 414.855, 414.857, 414.863, 414.865, 414.867, 414.869 and 414.900 and section 4, chapter 736, Oregon Laws 2003,** for a calendar quarter [*beginning before September 30, 2025*] **ending on or before December 31, 2032**.

SECTION 15. 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, section 40, chapter 538, Oregon Laws 2017, and section 16, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 14. Any moneys remaining in the Hospital Quality Assurance Fund on December 31, [*2031*] **2038**, are transferred to the General Fund.

OREGON HEALTH AND SCIENCE UNIVERSITY REIMBURSEMENT

SECTION 15a. Section 19, chapter 2, Oregon Laws 2019, is amended to read:

Sec. 19. (1) The amendments to section 41, chapter 538, Oregon Laws 2017, by section 17**, chapter 2, Oregon Laws 2019,** [*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*] **2032**.

(2) The amendments to section 41, chapter 538, Oregon Laws 2017, by section 18**, chapter 2, Oregon Laws 2019,** [*of this 2019 Act*] apply to reimbursement paid to the university by the authority on or after July 1, [*2025*] **2032**.

CONFORMING AMENDMENTS

SECTION 16. ORS 731.292 is amended to read:

731.292. (1) Except as provided in subsections (2), (3) and (4) of this section, all fees, charges and other moneys received by the Department of Consumer and Business Services or the Director of the Department of Consumer and Business Services under the Insurance Code shall be deposited in the fund created by ORS 705.145 and are continuously appropriated to the department for the payment of the expenses of the department in carrying out the Insurance Code.

(2) All taxes and penalties paid pursuant to the Insurance Code shall be paid to the director and after deductions of refunds shall be paid by the director to the State Treasurer, at the end of every calendar month or more often in the director's discretion, for deposit in the General Fund to become available for general governmental expenses.

(3) All premium taxes received by the director pursuant to ORS 731.820 shall be paid by the director to the State Treasurer for deposit in the State Fire Marshal Fund.

[*(4) Assessments received by the department under sections 3 and 5, chapter 538, Oregon Laws 2017, and penalties received by the department under section 6, chapter 538, Oregon Laws 2017, shall be paid into the State Treasury and credited to the Health System Fund established under section 2, chapter 538, Oregon Laws 2017.*]

SECTION 17. ORS 731.840 is amended to read:

731.840. (1) The retaliatory tax imposed upon a foreign or alien insurer under ORS 731.854 and 731.859, or the corporate excise tax imposed upon a foreign or alien insurer under ORS chapter 317, is in lieu of all other state taxes upon premiums, taxes upon income, franchise or other taxes measured by income that might otherwise be imposed upon the foreign or alien insurer except the fire insurance premiums tax imposed under ORS 731.820[*,*] **and** the tax imposed upon wet marine and transportation insurers under ORS 731.824 and 731.828 [*and the assessment imposed under section 5, chapter 538, Oregon Laws 2017*]. However, all real and personal property, if any, of the insurer shall be listed, assessed and taxed the same as real and personal property of like character of noninsurers. Nothing in this subsection shall be construed to preclude the imposition of the assessments imposed under ORS 656.612 upon a foreign or alien insurer.

(2) Subsection (1) of this section applies to a reciprocal insurer and its attorney in its capacity as such.

(3) Subsection (1) of this section applies to foreign or alien title insurers and to foreign or alien wet marine and transportation insurers issuing policies and subject to taxes referred to in ORS 731.824 and 731.828.

(4) The State of Oregon hereby preempts the field of regulating or of imposing excise, privilege, franchise, income, license, permit, registration, and similar taxes, licenses and fees upon insurers and their insurance producers and other representatives as such, and:

(a) No county, city, district, or other political subdivision or agency in this state shall so regulate, or shall levy upon insurers, or upon their insurance producers and representatives as such, any such tax, license or fee; except that whenever a county, city, district or other political subdivision levies or imposes generally on a nondiscriminatory basis throughout the jurisdiction of the taxing authority a payroll, excise or income tax, as otherwise provided by law, such tax may be levied or imposed upon domestic insurers; and

(b) No county, city, district, political subdivision or agency in this state shall require of any insurer, insurance producer or representative, duly authorized or licensed as such under the Insurance Code, any additional authorization, license, or permit of any kind for conducting therein transactions otherwise lawful under the authority or license granted under this code.

SECTION 18. ORS 291.055 is amended to read:

291.055. (1) Notwithstanding any other law that grants to a state agency the authority to establish fees, all new state agency fees or fee increases adopted during the period beginning on the date of adjournment sine die of a regular session of the Legislative Assembly and ending on the date of adjournment sine die of the next regular session of the Legislative Assembly:

(a) Are not effective for agencies in the executive department of government unless approved in writing by the Director of the Oregon Department of Administrative Services;

(b) Are not effective for agencies in the judicial department of government unless approved inwriting by the Chief Justice of the Supreme Court;

(c) Are not effective for agencies in the legislative department of government unless approved in writing by the President of the Senate and the Speaker of the House of Representatives;

(d) Shall be reported by the state agency to the Oregon Department of Administrative Services within 10 days of their adoption; and

(e) Are rescinded on adjournment sine die of the next regular session of the Legislative Assembly as described in this subsection, unless otherwise authorized by enabling legislation setting forth the approved fees.

(2) This section does not apply to:

(a) Any tuition or fees charged by a public university listed in ORS 352.002.

(b) Taxes or other payments made or collected from employers for unemployment insurance required by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

(A) Health care services provided by the Oregon Health and Science University, by the OregonVeterans' Homes pursuant to ORS 408.362 and 408.365 to 408.385 and by other state agencies and institutions pursuant to ORS 179.610 to 179.770.

(B) Copayments and premiums paid to the Oregon medical assistance program.

[*(C) Assessments paid to the Department of Consumer and Business Services under sections 3 and*

5, chapter 538, Oregon Laws 2017.]

(d) Fees created or authorized by statute that have no established rate or amount but are calculated for each separate instance for each fee payer and are based on actual cost of services provided.

(e) State agency charges on employees for benefits and services.

(f) Any intergovernmental charges.

(g) Forest protection district assessment rates established by ORS 477.210 to 477.265 and the Oregon Forest Land Protection Fund fees established by ORS 477.760.

(h) State Department of Energy assessments required by ORS 456.595 and 469.421 (8).

(i) Assessments on premiums charged by the Director of the Department of Consumer and Business Services pursuant to ORS 731.804 or fees charged by the director to banks, trusts and credit unions pursuant to ORS 706.530 and 723.114.

(j) Public Utility Commission operating assessments required by ORS 756.310 or charges paid to the Residential Service Protection Fund required by chapter 290, Oregon Laws 1987.

(k) Fees charged by the Housing and Community Services Department for intellectual property pursuant to ORS 456.562.

(L) New or increased fees that are anticipated in the legislative budgeting process for an agency, revenues from which are included, explicitly or implicitly, in the legislatively adopted budget or the legislatively approved budget for the agency.

(m) Tolls approved by the Oregon Transportation Commission pursuant to ORS 383.004.

(n) Portal provider fees as defined in ORS 276A.270 and established by the State Chief Information Officer under ORS 276A.276 (3) and recommended by the Electronic Government Portal Advisory Board.

(o) Fees set by the State Parks and Recreation Director and approved by the State Parks and Recreation Commission under ORS 390.124 (2)(b).

(3)(a) Fees temporarily decreased for competitive or promotional reasons or because of unexpected and temporary revenue surpluses may be increased to not more than their prior level without compliance with subsection (1) of this section if, at the time the fee is decreased, the state agency specifies the following:

(A) The reason for the fee decrease; and

(B) The conditions under which the fee will be increased to not more than its prior level.

(b) Fees that are decreased for reasons other than those described in paragraph (a) of this subsection may not be subsequently increased except as allowed by ORS 291.050 to 291.060 and 294.160. **SECTION 19.** ORS 243.135 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. The board shall impose a surcharge in an amount determined by the board on an eligible employee who arranges coverage for the employee's spouse or dependent under this subsection if the spouse or dependent has access to medical coverage as an employee in another health benefit plan offered by the board or the Oregon Educators Benefit Board.

(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 stateaccording 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) As frequently as is recommended as a commercial best practice by consultants engaged by the board, the board shall 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.

SECTION 20. ORS 317A.100, as amended by section 26, chapter 75, Oregon Laws 2024, is amended to read:

317A.100. As used in ORS 317A.100 to 317A.158:

(1)(a) "Commercial activity" means:

(A) The total amount realized by a person, arising from transactions and activity in the regular course of the person's trade or business, without deduction for expenses incurred by the trade or business;

(B) If received by a financial institution:

(i) If the reporting person for a financial institution is a holding company, all items of income reported on the FR Y-9 filed by the holding company;

(ii) If the reporting person for a financial institution is a bank organization, all items of income reported on the call report filed by the bank organization; and

(iii) If the reporting person for a financial institution is a nonbank financial organization, all items of income reported in accordance with generally accepted accounting principles; and

(C)(i) If received by an insurer, as reported on the statement of premiums accompanying the annual statement required under ORS 731.574 to be filed with the Director of the Department of Consumer and Business Services, all gross direct life insurance premiums, gross direct accident and health insurance premiums and gross direct property and casualty insurance premiums; and

(ii) The gross amount of surplus lines premiums received on Oregon home state risks as shown in the report required by ORS 735.465.

(b) "Commercial activity" does not include: (A)

Interest income except:

(i) Interest on credit sales; or

(ii) Interest income, including service charges, received by financial institutions;

(B) Receipts from the sale, exchange or other disposition of an asset described in section 1221 or 1231 of the Internal Revenue Code, without regard to the length of time the person held the asset;

(C) If received by an insurer, federally reinsured premiums or income from transactions between a reciprocal insurer and its attorney in fact operating under ORS 731.142;

(D) Receipts from hedging transactions, to the extent that the transactions are entered into primarily to protect a financial position, including transactions intended to manage the risk of exposure to foreign currency fluctuations that affect assets, liabilities, profits, losses, equity or investments in foreign operations, risk of exposure to interest rate fluctuations or risk of commodity price fluctuations;

(E) Proceeds received attributable to the repayment, maturity or redemption of the principal of a loan, bond, mutual fund, certificate of deposit or marketable instrument;

(F) The principal amount received under a repurchase agreement or on account of any transaction properly characterized as a loan to the person;

(G) Contributions received by a trust, plan or other arrangement, any of which is described in section 501(a) of the Internal Revenue Code, or to which title 26, subtitle A, chapter 1, subchapter (D) of the Internal Revenue Code applies;

(H) Compensation, whether current or deferred, and whether in cash or in kind, received or to be received by an employee, a former employee or the employee's legal successor for services rendered to or for an employer, including reimbursements received by or for an individual for medical or education expenses, health insurance premiums or employee expenses or on account of a dependent care spending account, legal services plan, any cafeteria plan described in section 125 of the Internal Revenue Code or any similar employee reimbursement;

(I) Proceeds received from the issuance of the taxpayer's own stock, options, warrants, puts or calls, or from the sale of the taxpayer's treasury stock;

(J) Proceeds received on the account of payments from insurance policies, including crop insurance policies, owned by the taxpayer, except those proceeds received for the loss of commercial activity;

(K) Gifts or charitable contributions received, membership dues received by trade, professional, homeowners' or condominium associations, payments received for educational courses, meetings or meals, or similar payments to a trade, professional or other similar association, and fundraising receipts received by any person when any excess receipts are donated or used exclusively for charitable purposes;

(L) Damages received as the result of litigation in excess of amounts that, if received without litigation, would be treated as commercial activity;

(M) Property, money and other amounts received or acquired by an agent on behalf of another in excess of the agent's commission, fee or other remuneration;

(N) Tax refunds from any tax program, other tax benefit recoveries and reimbursements for the tax imposed under ORS 317A.100 to 317A.158 made by entities that are part of the same unitary group as provided under ORS 317A.106, and reimbursements made by entities that are not members of a unitary group that are required to be made for economic parity among multiple owners of an entity whose tax obligation under ORS 317A.100 to 317A.158 is required to be reported and paid entirely by one owner, as provided in ORS 317A.106;

(O) Pension reversions;

(P) Contributions to capital;

(Q) Receipts from the sale, transfer, exchange or other disposition of motor vehicle fuel or any other product used for the propulsion of motor vehicles;

(R) In the case of receipts from the sale of cigarettes or tobacco products by a wholesale dealer, retail dealer, distributor, manufacturer or seller, an amount equal to the federal and state excise taxes paid by any person on or for such cigarettes or tobacco products under subtitle E of the Internal Revenue Code or ORS chapter 323;

(S) In the case of receipts from the sale of malt beverages or wine, as defined in ORS 471.001,cider, as defined in ORS 471.023 or distilled liquor, as defined in ORS 471.001, by a person holding a license issued under ORS chapter 471, an amount equal to the federal and state excise taxes paid by any person on or for such malt beverages, wine or distilled liquor under subtitle E of the Internal Revenue Code or ORS chapter 471 or 473, and any amount paid to the Oregon Liquor and Cannabis Commission for sales of distilled spirits by an agent appointed under ORS 471.750;

(T) In the case of receipts from the sale of marijuana items, as defined in ORS 475C.009, by a person holding a license issued under ORS 475C.005 to 475C.525, an amount equal to the federal and state excise taxes paid by any person on or for such marijuana items under subtitle E of the Internal Revenue Code or ORS 475C.670 to 475C.734 and any local retail taxes authorized under ORS 475C.453;

(U) Local taxes collected by a restaurant or other food establishment on sales of meals, prepared food or beverages;

(V) Tips or gratuities collected by a restaurant or other food establishment and passed on to employees;

(W) Receipts realized by a vehicle dealer certified under ORS 822.020 or a person described in ORS 320.400 (8)(a)(B) from the sale or other transfer of a motor vehicle, as defined in ORS 801.360, to another vehicle dealer for the purpose of resale by the transferee vehicle dealer, but only if the sale or other transfer was based upon the transferee's need to meet a specific customer's preference for a motor vehicle or is an exchange of new vehicles between franchised motor vehicle dealerships;

(X) Registration fees or taxes collected by a vehicle dealer certified under ORS 822.020 or a person described in ORS 320.400 (8)(a)(B) at the sale or other transfer of a motor vehicle, as defined in ORS 801.360, that are owed to a third party by the purchaser of the motor vehicle and passed to the third party by the dealer;

(Y) Receipts from a financial institution for services provided to the financial institution in connection with the issuance, processing, servicing and management of loans or credit accounts, if the financial institution and the recipient of the receipts have at least 50 percent of their ownership interests owned or controlled, directly or constructively through related interests, by common owners;

(Z) In the case of amounts retained as commissions by a holder of a license under ORS chapter462, an amount equal to the amounts specified under ORS chapter 462 that must be paid to or collected by the Department of Revenue as a tax and the amounts specified under ORS chapter 462 to be used as purse money;

(AA) Receipts of residential care facilities as defined in ORS 443.400 or in-home care agencies as defined in ORS 443.305, to the extent that the receipts are derived from or received as compensation for providing services to a medical assistance or Medicare recipient;

(BB)Dividends received;

(CC)Distributive income received from a pass-through entity;

(DD) Receipts from sales to a wholesaler in this state, if the seller receives certification at the time of sale from the wholesaler that the wholesaler will sell the purchased property outside this state;

(EE) Receipts from the wholesale or retail sale of groceries, including receipts of a person that owns groceries at the time of sale and compensation of any consignee engaged in effecting the sale of groceries on behalf the owner of the groceries, but only to the extent that the compensation relates to grocery sales;

(FF) Receipts from transactions among members of a unitary group;

(GG) Moneys, including public purpose charge moneys collected under ORS 757.612 and moneys collected to plan for and pursue cost-effective energy efficiency resources under ORS 757.054, that are collected from customers, passed to a utility and approved by the Public Utility Commission and that support energy conservation, renewable resource acquisition and low-income assistance programs;

(HH) Moneys collected by a utility from customers for the payment of loans through on-bill financing;

(II) Surcharges collected under ORS 757.736;

(JJ) Moneys passed to a utility by the Bonneville Power Administration for the purpose of effectuating the Regional Power Act Exchange credits or pursuant to any settlement associated with the exchange credit;

(KK) Moneys collected or recovered, by entities listed in ORS 756.310, cable operators as defined in 47 U.S.C. 522(5), telecommunications carriers as defined in 47 U.S.C. 153(51) and providers of information services as defined in 47 U.S.C. 153(24), for fees payable under ORS 756.310, right-of-way fees, franchise fees, privilege taxes, federal taxes and local taxes;

(LL) Charges paid to the Residential Service Protection Fund required by chapter 290, Oregon Laws 1987;

(MM) Universal service surcharge moneys collected or recovered and paid into the universal service fund established in ORS 759.425;

(NN) Moneys collected for public purpose funding as described in ORS 759.430;

(OO) Moneys collected or recovered and paid into the federal universal service fund as determined by the Federal Communications Commission;

(PP) In the case of a seller or provider of telecommunications services, the amount of tax imposed under ORS 403.200 for access to the emergency communications system that is collected from subscribers or consumers;

(QQ) In the case of a transient lodging tax collector, the amount of tax imposed under ORS320.305 and of any local transient lodging tax imposed upon the occupancy of transit lodging;

(RR) In the case of a seller of bicycles, the amount of tax imposed under ORS 320.415 upon retail sales of bicycles;

(SS) In the case of a qualified heavy equipment provider, the amount of tax imposed under ORS307.872 upon the rental price of heavy equipment;

(TT) Farmer sales to an agricultural cooperative in this state that is a cooperative organization described in section 1381 of the Internal Revenue Code;

(UU) Revenue received by a business entity that is mandated by contract or subcontract to be distributed to another person or entity if the revenue constitutes sales commissions that are paid to a person who is not an employee of the business entity, including, without limitation, a split-fee real estate commission;

(VV) Receipts from the sale of fluid milk by dairy farmers that are not members of an agricultural cooperative; and

(WW)(i) Cost paid by a dealer for items of precious metal.

(ii) As used in this subparagraph, "item of precious metal" means an item of gold, silver, platinum, rhodium or palladium that has been put through a process of smelting or refining and that is in a state or condition that its value depends on its contents and not its form.

(2) "Cost inputs" means:

(a) The cost of goods sold as calculated in arriving at federal taxable income under the Internal Revenue Code; or

(b) In the case of a taxpayer that is engaged in a farming operation, as defined in ORS 317A.102,and that does not report cost of goods sold for federal tax purposes, the taxpayer's operating expenses excluding labor costs.

(3) "Doing business" means engaging in any activity, whether legal or illegal, that is conducted for, or results in, the receipt of commercial activity at any time during a calendar year.

(4) "Excluded person" means any of the following:

(a) Organizations described in sections 501(c) and 501(j) of the Internal Revenue Code, unless the exemption is denied under section 501(h), (i) or (m) or under section 502, 503 or 505 of the Internal Revenue Code.

(b) Organizations described in section 501(d) of the Internal Revenue Code, unless the exemption is denied under section 502 or 503 of the Internal Revenue Code.

(c) Organizations described in section 501(e) of the Internal Revenue Code.

(d) Organizations described in section 501(f) of the Internal Revenue Code.

(e) Charitable risk pools described in section 501(n) of the Internal Revenue Code.

(f) Organizations described in section 521 of the Internal Revenue Code.

(g) Qualified state tuition programs described in section 529 of the Internal Revenue Code.

(h) Foreign or alien insurance companies, but only with respect to the underwriting profit derived from writing wet marine and transportation insurance subject to tax under ORS 731.824 and 731.828 or if an insurance company is subject to the retaliatory tax under ORS 731.854 and 731.859. (i) Governmental entities.

(j) Any person with commercial activity that does not exceed $750,000 for the tax year, other than a person that is part of a unitary group as provided in ORS 317A.106 with commercial activity in excess of $750,000.

(k) [*Hospitals subject to assessment under ORS 414.855,*] Long term care facilities subject to assessment under ORS 409.801 [*or any entity subject to assessment under ORS 414.880 or section 3 or 5, chapter 538, Oregon Laws 2017*].

(L) Manufactured dwelling park nonprofit cooperatives organized under ORS chapter 62.

(5) "Financial institution" has the meaning given that term in ORS 314.610, except that "financial institution" does not include a credit union.

(6)(a) "FR Y-9" means the consolidated or parent-only financial statements that a holding company is required to file with the Federal Reserve Board pursuant to 12 U.S.C. 1844.

(b) In the case of a holding company required to file both consolidated and parent-only financial statements, "FR Y-9" means the consolidated financial statements that the holding company is required to file.

(7) "Governmental entity" means:

(a) The United States and any of its unincorporated agencies and instrumentalities.

(b) Any incorporated agency or instrumentality of the United States wholly owned by the United States or by a corporation wholly owned by the United States.

(c) The State of Oregon and any of its unincorporated agencies and instrumentalities.

(d) Any county, city, district or other political subdivision of the state.

(e) A special government body as defined in ORS 174.117.

(f) A federally recognized Indian tribe.

(8) "Groceries" means food as defined in 7 U.S.C. 2012(k), but does not include cannabinoid edibles or marijuana seeds.

(9)(a) "Hedging transaction" means a hedging transaction as defined in section 1221 of the Internal Revenue Code or a transaction accorded hedge accounting treatment under Financial Accounting Standards Board Statement No. 133.

(b) "Hedging transaction" does not include a transaction in which an actual transfer of title of real or tangible property to another entity occurs.

(10) "Insurer" has the meaning given that term in ORS 317.010.

(11) "Internal Revenue Code," except where the Legislative Assembly has provided otherwise, refers to the laws of the United States or to the Internal Revenue Code as they are amended and in effect on December 31, 2023.

(12) "Labor costs" means total compensation of all employees, not to include compensation paid to any single employee in excess of $500,000.

(13)(a) "Motor vehicle fuel or any other product used for the propulsion of motor vehicles" means:

(A) Motor vehicle fuel as defined in ORS 319.010; and

(B) Fuel the use of which in a motor vehicle is subject to taxation under ORS 319.530.

(b) "Motor vehicle fuel or any other product used for the propulsion of motor vehicles" does not mean:

(A) Electricity; or

(B) Electric batteries or any other mechanical or physical component or accessory of a motor vehicle.

(14) "Person" includes individuals, combinations of individuals of any form, receivers, assignees, trustees in bankruptcy, firms, companies, joint-stock companies, business trusts, estates, partnerships, limited liability partnerships, limited liability companies, associations, joint ventures, clubs, societies, entities organized as for-profit corporations under ORS chapter 60, C corporations, S corporations, qualified subchapter S subsidiaries, qualified subchapter S trusts, trusts, entities that are disregarded for federal income tax purposes and any other entities.

(15) "Retailer" means a person doing business by selling tangible personal property to a purchaser for a purpose other than:

(a) Resale by the purchaser of the property as tangible personal property in the regular course of business;

(b) Incorporation by the purchaser of the property in the course of regular business as an ingredient or component of real or personal property; or

(c) Consumption by the purchaser of the property in the production for sale of a new article of tangible personal property.

(16) "Taxable commercial activity" means commercial activity sourced to this state under ORS 317A.128, less any subtraction pursuant to ORS 317A.119.

(17)(a) "Taxpayer" means any person or unitary group required to register, file or pay tax under ORS 317A.100 to 317A.158.

(b) "Taxpayer" does not include excluded persons, except to the extent that a tax-exempt entity has unrelated business income as described in the Internal Revenue Code.

(18) "Tax year" means, except as otherwise provided in ORS 317A.103, a taxpayer's annual accounting period used for federal income tax purposes under section 441 of the Internal Revenue Code.

(19)(a) "Unitary business" means a business enterprise in which there exists directly or indirectly between the members or parts of the enterprise a sharing or exchange of value as demonstrated by:

(A) Centralized management or a common executive force;

(B) Centralized administrative services or functions resulting in economies of scale; or(C) Flow of goods, capital resources or services demonstrating functional integration.

(b) "Unitary business" may include a business enterprise the activities of which:

(A) Are in the same general line of business, such as manufacturing, wholesaling or retailing; or

(B) Constitute steps in a vertically integrated process, such as the steps involved in the production of natural resources, which might include exploration, mining, refining and marketing.

(20) "Unitary group" means a group of persons with more than 50 percent common ownership, either direct or indirect, that is engaged in business activities that constitute a unitary business.

(21) "Wholesaler" means a person primarily doing business by merchant distribution of tangible personal property to retailers or to other wholesalers.

SECTION 21. ORS 415.500 is amended to read:

415.500. As used in this section and ORS 415.501 and 415.505:

(1) "Corporate affiliation" has the meaning prescribed by the Oregon Health Authority by rule, including: (a) Any relationship between two organizations that reflects, directly or indirectly, a partial or complete controlling interest or partial or complete corporate control; and (b) Transactions that merge tax identification numbers or corporate governance.

(2) "Essential services" means:

(a) Services that are funded on the prioritized list described in ORS 414.690; and (b) Services that are essential to achieve health equity.

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

(4)(a) "Health care entity" includes:

(A) An individual health professional licensed or certified in this state;

(B) A hospital, as defined in ORS 442.015, or hospital system, as defined by the authority by rule;

(C) A carrier, as defined in ORS 743B.005, that offers a health benefit plan in this state;

(D) A Medicare Advantage plan;

(E) A coordinated care organization or a prepaid managed care health services organization, as both terms are defined in ORS 414.025; and

(F) Any other entity that has as a primary function the provision of health care items or services or that is a parent organization of, or is an entity closely related to, an entity that has as a primary function the provision of health care items or services.

(b) "Health care entity" does not include:

(A) Long term care facilities, as defined in ORS 442.015.

(B) Facilities licensed and operated under ORS 443.400 to 443.455.

(5) "Health equity" has the meaning prescribed by the Oregon Health Policy Board and adopted by the

authority by rule.

(6)(a) "Material change transaction" means:

(A) A transaction in which at least one party had average revenue of $25 million or more in the preceding three fiscal years and another party:

(i) Had an average revenue of at least $10 million in the preceding three fiscal years; or

(ii) In the case of a new entity, is projected to have at least $10 million in revenue in the first full year of operation at normal levels of utilization or operation as prescribed by the authority by rule.

(B) If a transaction involves a health care entity in this state and an out-of-state entity, a transaction that otherwise qualifies as a material change transaction under this paragraph that may result in increases in the price of health care or limit access to health care services in this state.

(b) "Material change transaction" does not include:

(A) A clinical affiliation of health care entities formed for the purpose of collaborating on clinical trials or graduate medical education programs.

(B) A medical services contract or an extension of a medical services contract.

(C) An affiliation that:

(i) Does not impact the corporate leadership, governance or control of an entity; and

(ii) Is necessary, as prescribed by the authority by rule, to adopt advanced value-based payment methodologies to meet the health care cost growth targets under ORS 442.386.

(D) Contracts under which one health care entity, for and on behalf of a second health care entity, provides patient care and services or provides administrative services relating to, supporting or facilitating the provision of patient care and services, if the second health care entity: (i) Maintains responsibility, oversight and control over the patient care and services; and (ii) Bills and receives reimbursement for the patient care and services.

(E) Transactions in which a participant that is a health center as defined in 42 U.S.C. 254b,while meeting all of the participant's obligations, acquires, affiliates with, partners with or enters into any agreement with another entity unless the transaction would result in the participant no longer qualifying as a health center under 42 U.S.C. 254b.

(7)(a) "Medical services contract" means a contract to provide medical or mental health services entered into by:

(A) A carrier and an independent practice association;

(B) A carrier, coordinated care organization, independent practice association or network of providers and one or more providers, as defined in ORS 743B.001;

(C) An independent practice association and an individual health professional or an organization of health care providers;

(D) Medical, dental, vision or mental health clinics; or

(E) A medical, dental, vision or mental health clinic and an individual health professional to provide medical, dental, vision or mental health services.

(b) "Medical services contract" does not include a contract of employment or a contract creating a legal entity and ownership of the legal entity that is authorized under ORS chapter 58, 60 or 70 or under any other law authorizing the creation of a professional organization similar to those authorized by ORS chapter 58, 60 or 70, as may be prescribed by the authority by rule.

(8) "Net patient revenue" means the total amount of revenue, after allowance for contractual amounts, charity care and bad debt, received for patient care and services, including:

(a) Value-based payments;

(b) Incentive payments; **and**

(c) Capitation payments or payments under any similar contractual arrangement for the prepayment or reimbursement of patient care and services[*; and*]

[*(d) Any payment received by a hospital to reimburse a hospital assessment under ORS 414.855*].

(9) "Revenue" means:

(a) Net patient revenue; or

(b) The gross amount of premiums received by a health care entity that are derived from health benefit plans.

(10) "Transaction" means:

(a) A merger of a health care entity with another entity;

(b) An acquisition of one or more health care entities by another entity;

(c) New contracts, new clinical affiliations and new contracting affiliations that will eliminate or significantly reduce, as defined by the authority by rule, essential services;

(d) A corporate affiliation involving at least one health care entity; or

(e) Transactions to form a new partnership, joint venture, accountable care organization, parent organization or management services organization, as prescribed by the authority by rule.

CAPTIONS

SECTION 22. The unit captions used in this 2025 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 2025 Act.

OPERATIVE DATE AND EFFECTIVE DATE

SECTION 23. The amendments to ORS 243.135, 291.055, 317A.100, 415.500, 731.292, 731.509 and 731.840 by sections 4 and 16 to 21 of this 2025 Act become operative on January 2, 2038.

SECTION 24. This 2025 Act takes effect on the 91st day after the date on which the 2025 regular session of the Eighty-third Legislative Assembly adjourns sine die.

Passed by House February 27, 2025

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

.....
Julie Fahey, Speaker of House **Passed by Senate March 17, 2025**

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2025

Approved:

.....M.,....., 2025

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2025

.....
Tobias Read, Secretary of State

Appendix 2 – Oregon Administrative Rules 836-150-0010 to 0060

OREGON REINSURANCE PROGRAM
836-150-0010
Purpose and Statutory Authority

The purpose of OAR 836-150-0010 to 836-150-0060 is to administer the Oregon Reinsurance Program established in the Department of Consumer and Business Services for the purposes of stabilizing the rates and premiums for individual health benefit plans and providing greater financial certainty to consumers of health insurance in this state.

Statutory/Other Authority: ORS 731.244 & 2017 Or Laws ch 538 sec 19
Statutes/Other Implemented: 2017 Or Laws ch 538 sec 18-21
History:
ID 38-2018, adopt filed 12/19/2018, effective 01/01/2019

836-150-0020
Definitions

The terms used in OAR 836-150-0010 to 836-150-0060 have the meaning prescribed in section 19, chapter 538, Oregon Laws 2017 (Enrolled House Bill 2391) and:

(1) "Benefit year" means a calendar year beginning on or after January 1, 2018 for which a reinsurance eligible health benefit plan provides health insurance coverage.

(2) "Department" means the Oregon Department of Consumer and Business Services.

(3) "Reinsurance eligible claim" means a claim for services covered under a reinsurance eligible health benefit plan that is incurred by a reinsurance eligible issuer during a benefit year and paid by the reinsurance eligible issuer before July 1 of the following year.

(4) "Reinsurance eligible issuer" means an insurer or health care service contractor who offers a reinsurance eligible health benefit plan to reinsurance eligible individuals.

(5) "Reinsurance payment" means payments issued to a reinsurance eligible issuer in accordance with section 2(3), chapter 538 Oregon Laws 2017 (Enrolled House Bill 2391) and OAR 836-150-0050.

Statutory/Other Authority: ORS 731.244 & 2017 Or Laws ch 538 sec 19
Statutes/Other Implemented: 2017 Or Laws ch 538 sec 18-21
History:
ID 38-2018, adopt filed 12/19/2018, effective 01/01/2019

836-150-0030
Information Reporting

(1) As a condition of receiving reinsurance payments from the Oregon Reinsurance Program, a reinsurance eligible issuer must provide, for each benefit year, the following information to

the department in the form and manner prescribed by the department:

(a) The name and company code assigned to the reinsurance eligible issuer by the National Association of Insurance Commissioners;

(b) The identification number assigned to the reinsurance eligible issuer by the Health Insurance Oversight System (HIOS);

(c) The total amount of the reinsurance eligible issuer's reinsurance eligible claims for the benefit year;

(d) The portion of the reinsurance eligible issuer's total reinsurance eligible claims for the benefit year that fall between the attachment point and reinsurance cap;

(e) A summary data file containing the following information for each reinsurance eligible individual with claims for which reinsurance payments are being requested:

(A) The member identification number assigned by the reinsurance eligible issuer to the reinsurance eligible individual;

(B) The start and end dates of coverage for the reinsurance eligible individual;

(C) The HIOS plan identification number for the reinsurance eligible health benefit plan in which the reinsurance eligible individual was enrolled;

(D) The total amount of reinsurance eligible claims for the reinsurance eligible individual for the benefit year; and

(E) The total amount of reinsurance eligible claims for the reinsurance eligible individual for the benefit year that fall between the attachment point and reinsurance cap;

(f) A detailed claims file extracted from the reinsurance eligible issuer's claims processing system that includes the issuer's complete record of all reinsurance eligible claims for the benefit year;

(g) An attestation signed by an executive officer of the reinsurance eligible issuer stating that the information is accurate as of the date of submission; and

(h) Any other information requested by the department.

(2) As a condition of receiving reinsurance payments from the Oregon Reinsurance Program, a reinsurance eligible issuer must submit the information required under this rule to the department:

(a) Using a secure method of transmission approved by the department; and

(b) On or before July 15 of the year following the benefit year for which the reinsurance payment is requested.

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

History:
ID 38-2018, adopt filed 12/19/2018, effective 01/01/2019

836-150-0040
Reinsurance Parameters

(1) 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.

(2) For the benefit year beginning on January 1, 2023 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 fifty percent.

(3) For the benefit year beginning on January 1, 2024 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 fifty percent.

(4) For the benefit year beginning on January 1, 2025 the parameters for the Oregon Reinsurance Program are:

(a) An attachment point of $103,000;

(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, 2026 the parameters for the Oregon Reinsurance Program are:

(a) An attachment point of $108,000;

(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
History:
ID 8-2025, amend filed 11/17/2025, effective 01/01/2026
ID 1-2025, amend filed 01/16/2025, effective 01/16/2025
ID 55-2023, amend filed 12/21/2023, effective 01/01/2024
ID 1-2023, amend filed 01/24/2023, effective 01/31/2023
ID 12-2021, amend filed 12/16/2021, effective 01/01/2022
ID 2-2021, amend filed 01/21/2021, effective 02/01/2021
ID 2-2020, amend filed 04/24/2020, effective 04/24/2020
ID 8-2019, temporary amend filed 10/25/2019, effective 10/25/2019 through 04/21/2020
ID 38-2018, adopt filed 12/19/2018, effective 01/01/2019

836-150-0050
Reinsurance Payments

(1) The department will calculate the total reinsurance payment owed to each reinsurance eligible issuer.

(a) Subject to paragraph (b) and (c) of this rule, the reinsurance payment made to each reinsurance eligible issuer for a benefit year will be the product of the coinsurance rate and the portion of the reinsurance eligible issuer's total reinsurance eligible claims for the benefit year that fall between the attachment point and the reinsurance cap.

(b) If the total reinsurance payments calculated under paragraph (a) of this rule would exceed the total dollar amount budgeted for the reinsurance program in a benefit year, the department may uniformly reduce the coinsurance rate for all reinsurance eligible issuers in that benefit year. If the department elects to reduce the coinsurance rate under this paragraph, the department will reduce the coinsurance rate only to the extent necessary to ensure that reinsurance payments do not exceed the total dollar amount budgeted for the benefit year.

(c) In making the calculation under paragraph (a), the department may disregard any or all reinsurance eligible claims reported by a reinsurance eligible issuer under OAR 836-150-0030 that cannot be verified as part of the audit described under OAR 836-150-0060(1).

(2) The department will issue reinsurance payments to all reinsurance eligible issuers on an annual basis in the year following each benefit year.

(3) Payments will be made directly to reinsurance eligible issuers by a method selected by the department.

Statutory/Other Authority: ORS 731.244 & 2017 Or Laws ch 538 sec 19
Statutes/Other Implemented: 2017 Or Laws ch 538 sec 18-21
History:
ID 38-2018, adopt filed 12/19/2018, effective 01/01/2019

836-150-0060
Duties of the Administrator

As administrator of the Oregon Reinsurance program, the department will:

(1) Conduct an audit of the information submitted under 836-150-0030.

(2) Notify reinsurance eligible issuers of the results of the calculation described under 836-150-0050, including any modifications of the coinsurance rate.

(3) Issue reinsurance payments to each reinsurance eligible issuer in accordance with OAR 836-150-0050.

Statutory/Other Authority: ORS 731.244 & 2017 Or Laws ch 538 sec 19
Statutes/Other Implemented: 2017 Or Laws ch 538 sec 18-21
History:
ID 38-2018, adopt filed 12/19/2018, effective 01/01/2019

Appendix 3 – Public Comments

TINA KOTEK GOVERNOR

April 28, 2026

The Honorable Robert F. Kennedy, Jr. Secretary
U.S. Department of Health and Human Services 200 Independence Avenue, S.W.
Washington, D.C. 20201 Dear Secretary Kennedy:

I am writing to express my support for extending Oregon's 1332 Waiver for program years 2028 through 2032. In Oregon we are fully committed to ensuring all Oregonians can access high-quality, affordable health coverage and to working collaboratively with our federal, local, tribal, and carrier partners to maintain a stable, accessible insurance market. The 1332 Waiver has been vital to stabilizing the state's individual health insurance market with the Oregon Reinsurance Program and I strongly endorse our extension application.

Since its inception in 2018, the Oregon Reinsurance Program (ORP) has been central to Oregon's robust health care market and the overall health of the over 175,000 middle-income Oregonians who individually purchase insurance every year. For each of its past eight years, the ORP has lowered premium rates by an average of 8.5 percent for consumers on the health insurance marketplace. For the 2028 program year and beyond, we estimate that Oregonians will continue to save up to 8.5 percent on health plans from the individual market.

Additionally, the ORP has helped stabilize plan options and has encouraged carrier growth and competition across Oregon. In 2021, when we last applied for a waiver extension, Oregon had at least three carriers in all 36 counties. Currently, with the continued and stabilizing presence of the ORP, Oregon has at least five carriers offering plans in all 36 counties. We are proud to help provide Oregonians with a choice of multiple options so they can choose a health plan that works best for them. In particular, we are proud that ORP has notably improved rate stability and plan options for the rural areas of the state that historically have had the highest premiums and fewest carrier choices.

The U.S. Department of Health and Humans Services approval of the PPACA 1332 waiver extension for the next five years is a critical component of maintaining and improving the strength of Oregon's health insurance market. We look forward to continuing to partner with you on this waiver program and other initiatives that help provide all Oregonians with high-quality and accessible health care.

Sincerely,

Governor Tina Kotek

254 STATE CAPITOL, SALEM OR 97301-4047 (503) 378-4582 FAX (503) 378-8970 WWW.GOVERNOR.OREGON.GOV

Exhibit 2 - AARP

1455 SW Broadway, Suite 1490, Portland, OR 97201
(866) 554-5360 | aarp.org/or | oraarp@aarp.org
twitter: @aarpor | facebook.com/AARPOregon

April 7, 2026 TK Keen
Oregon Insurance Commissioner
Oregon Department of Consumer and Business Services 350 Winter Street NE
Salem, OR 97309

Dear Commissioner Keen,

AARP Oregon writes to reaffirm our strong support for Oregon's application to renew the State Relief and Empowerment waiver under Section 1332 of the Affordable Care Act for the 2028–2032 program years. This waiver allows Oregon to continue operating the Oregon Reinsurance Program, which has played an important role in lowering health insurance premiums and expanding access to more affordable, quality coverage for Oregonians.

The Oregon Reinsurance Program has helped stabilize the individual insurance market and reduce costs for individuals and families purchasing coverage. Over the past five years, the program has generated approximately $567 million in savings for Oregonians purchasing individual coverage, based on the portion of high-cost claims covered through the reinsurance program. Market stability remains essential to ensuring long-term access to coverage, particularly for older adults and individuals nearing Medicare eligibility who rely on affordable individual market plans.

By reimbursing insurers for a portion of high-cost claims, the reinsurance program helps reduce premium growth while maintaining access to comprehensive coverage. This approach continues to deliver meaningful financial relief and market stability for consumers across the state.

Thank you for the opportunity to express AARP Oregon's continued support for the renewal of Oregon's Section 1332 waiver for the 2028–2032 period. We look forward to continued collaboration with the Division of Financial Regulation and the Department of Consumer and Business Services to advance affordable, quality health coverage for all Oregonians.

Please feel free to contact me at BShrestha@aarp.org if you have any questions.

Sincerely,

Bandana Shrestha
State Director
AARP Oregon

Exhibit 3 - PacificSource Health Plans



April 1, 2026

TK Keen, Oregon Insurance Commissioner Department of Consumer and Business Services Division of Financial Regulation
350 Winter Street NE Salem, OR 97309

Delivered via email: TK.KEEN@dcbs.oregon.gov

Re: Oregon Reinsurance Program Public Comments for 2028-2032 PPACA § 1332 Waiver Extension

Dear Commissioner Keen:

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 three states. PacificSource Community Solutions is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia River Gorge, and Marion & Polk Counties. 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 2028-2032. As you know, the waiver implemented Oregon law[1] 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); 2025 Or Laws ch 4 (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 pans 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,

John Espinola, MD President and CEO

Cc: Alex Cheng, Deputy Administrator, Division of Financial Regulation Kirsten Anderson, Deputy Administrator, Division of Financial Regulation Joel Payton, Oregon Reinsurance Program Manager

Exhibit 4 – Project Access Now

PROJECTACCESSNOW

April 2nd, 2026

Re: Oregon Reinsurance Program and 1332 PPACA Waiver

Dear Mr. TK Keen:

I am writing today on behalf of Project Access NOW's (PANOW) to express our support for the renewal of Oregon's PPACA 1332 Waiver and the Oregon Reinsurance Program (ORP), which greatly increases our capacity to deliver the critical programs we offer to the communities we serve. PANOW's mission is to improve our communities' health and wellbeing by creating access to care, services, and resources for those most in need. In pursuit of that mission, PANOW operates an Insurance Enrollment & Payment Support program which pays the health insurance premiums of clients who earn slightly too much to qualify for Medicaid, but too little to afford premiums and out-of-pocket costs.

This month (April 2026), the program paid the monthly premiums of 250 program enrollees. Every dollar that the reinsurance program is able to reduce monthly premium rates on the Marketplace by means another dollar that we can dedicate to serving another individual in the Insurance Enrollment & Payment Support program. Keeping premiums affordable is more critical than ever now, after the expiration of the American Rescue Plan Act (ARPA) federal enhanced tax credit subsidies at the end of 2025 increased consumer financial burden on the Marketplace even further. The reduction of these tax credits has meant PANOW has to pay even more for every client we cover in this program.

The ORP keeps premium costs low for consumers and allows organizations like PANOW to ultimately serve more community members in need. We urge the Oregon legislature and federal government to support the ORP for another five-year term in the upcoming 1332 waive approval. 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.

Sincerely,

Tracy Carver

Tracy Carver

President & CEO

www.projectaccessnow.org | (503) 345-6553 | info@projectaccessnow.org
In-Person By Appointment | 650 NE Holladay St, Suite 1700, Portland, OR 97232

Exhibit 5 – Regence BlueCross BlueShield of Oregon

Regence | 200 SW Market Street,
11th Floor Portland, OR 97201

April 2, 2026

TK Keen, Oregon Insurance Commissioner Attention: Joel Payton, ORP Program Manager 350 Winter Street NE
Salem, OR 97301

Re: Support for Oregon Reinsurance Program 2028-2032 PPACA 1332 Waiver Extension

Dear Commissioner Keen:

Regence BlueCross BlueShield of Oregon ("Regence") appreciates the opportunity to support Oregon's application to extend the Patient Protection and Affordable Care Act Section 1332 State Innovation and Empowerment Waiver through 2032, and we respectfully request that the program be approved and extended.

Regence has served Oregon and its residents for over 80 years, and 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 have consistently supported the Oregon Reinsurance Program since its inception. 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 exceptional results. The program has successfully stabilized Oregon's individual health insurance market by reimbursing insurers for a portion of high-cost claims paid on behalf of enrollees. As a result, the ORP has reduced individual health plan premiums by $740 million from 2018-2024, helping insurers pay for high-cost claims while lowering premium rates for individuals who select healthcare plans on the individual market.

The program's success extends beyond premium reduction. Service areas have expanded to at least five or six plan options throughout Oregon's 36

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence | 200 SW Market Street,
11th Floor Portland, OR 97201

counties and tribal lands on the individual market. Since 2018, the ORP has helped maintain an average enrollment on the individual marketplace of over 172,000 members annually, demonstrating the program's vital role in ensuring access to affordable coverage.

We strongly encourage the U.S. Department of Health and Human Services and the U.S. Department of Treasury to approve the waiver extension request so this valuable program may continue through 2032. Approval of the waiver will continue to stabilize the individual market in Oregon and deliver meaningful benefits to consumers.

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
(Michael.Cole@regence.com) or Mary Anne Cooper, our Director of Public Affairs and Government Relations (MaryAnne.Cooper@cambiahealth.com), with any questions.



Sincerely,

Michael Cole, President
Regence BlueCross BlueShield of Oregon

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Exhibit 6 – Providence Health Plan

Providence
Health Plan
P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthPlan.com

Thursday, March 12, 2026

TK Keen, Oregon Insurance Commissioner and DFR Administrator
Attention: Joel Payton, ORP Program Manager
350 Winter Street, NE
Salem, OR 97301

Re: Support for the Extension of Oregon's Section 1332 Waiver; the Oregon Reinsurance Program (2028–2032)

Dear Commissioner Keen,

Providence Health Plan (PHP) is a nonprofit, provider-aligned health insurer headquartered in Oregon and serving communities across the Pacific Northwest. Our health plan provides coverage to hundreds of thousands of members through a range of commercial, individual, Medicare, and Medicaid products. We are part of the broader Providence health system, which operates hospitals, clinics, and care services throughout the western United States.

In Oregon, Providence Health Plan plays a significant role in the state's health insurance marketplace. The plan participates across multiple market segments, including the individual, small group, large group, and Medicare Advantage markets. Providence has historically maintained one of the largest shares of Oregon's individual marketplace exchange and is among the leading commercial insurers in the state.

Support for Oregon's Section 1332 Waiver Extension

Providence Health Plan appreciates the opportunity to provide comments in support of Oregon's request to extend its Patient Protection and Affordable Care Act (ACA) Section 1332 State Innovation Waiver for the Oregon Reinsurance Program (ORP) for plan years 2028 through 2032.[1]

Providence Health Plan strongly supports the continuation of the Oregon Reinsurance Program and the state's request to extend the waiver. Since its implementation in 2018, ORP has played a critical role in stabilizing Oregon's individual health insurance market by mitigating the financial

[1] Or. Dep't of Consumer & Bus. Servs., Letter from TK Keen, Ins. Comm'r, to the Ctrs. for Medicare & Medicaid Servs. Regarding Oregon's Section 1332 Waiver Extension (2025).

volatility associated with high-cost claims and improving the predictability of insurer risk pools. These outcomes have benefited both insurers and consumers by promoting a more stable individual market.

Market Stability and Risk Pool Protection

The individual market is particularly sensitive to shifts in risk composition. A relatively small number of high-cost claims can significantly influence premiums in a market with limited enrollment. By reimbursing insurers for a portion of high-cost claims, ORP reduces the concentration of catastrophic risk borne by individual carriers. This structure spreads risk more broadly across the market and allows insurers to set premiums that more accurately reflect the underlying population risk rather than the unpredictable impact of outlier claims.

Improving Premium Affordability for Consumers

As a result, the program has meaningfully improved premium affordability for Oregon consumers. The Oregon Department of Consumer and Business Services estimates that ORP reduced premiums in the individual market by approximately $740 million between 2018 and 2024. By lowering premiums, the program helps maintain coverage affordability for individuals and families who purchase insurance without access to employer-sponsored coverage. In turn, that affordability brings in a larger number of enrollees, which also helps to stabilize the market.

Supporting Market Participation and Consumer Choice

Equally important, the program has strengthened market participation and consumer choice. Stabilizing the financial risk associated with the individual market allows insurers to maintain or expand service areas and continue offering coverage options throughout the state. Today, Oregon consumers generally have access to multiple plan options across all counties and tribal lands in the individual market, supporting meaningful competition and choice. Providence Health Plan provides individual market coverage in all counties across the state of Oregon.

Legislative Support and Program Continuity

The Oregon Legislature continued its commitment to the program by passing House Bill 2010 (2025), which extends the funding structure that supports ORP through December 31, 2032.[2] This legislation provides long-term stability and ensures that Oregon can continue to operate the program in a fiscally sustainable manner.

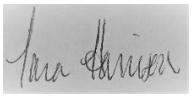
[2] 2025 Or. Laws ch. 4, § 1-5 (H.B. 2010).

Providence
Health Plan
P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthPlan.com

The ORP continues to align closely with the limits on Section 1332 waivers. The program lowers premiums, improves market stability, and supports sustained coverage availability without increasing federal spending. By easing premium growth and rapid risk shifts, the program contributes to a healthier and more predictable individual market that benefits both consumers and participating insurers.

The Oregon Reinsurance Program demonstrates how state innovation waivers successfully address market challenges. Extending the waiver will allow Oregon to build on the program's success and continue providing meaningful premium relief and market stability for consumers in Oregon.

Sincerely,



Tara Harrison, JD Government
Affairs Director Providence
Health Plan

Exhibit 7 – Kaiser Permanente

From: Wendy N Watson
Sent: Tuesday, March 10, 2026 5:05 PM
To: KEEN TK * DCBS
Cc: Jen Lewis-Goff
Subject: RE: Oregon DFR Request for Support-Reinsurance Program

Director Keen,

Thank you for your letter dated February 19th, seeking Kaiser Permanente comments in response to Oregon' s reinsurance program's waiver extension. While Kaiser Permanente is a strong supporter of the reinsurance program, we typically do not comment on 1332 waiver extension requests for reinsurance programs unless a state is proposing to make significant changes to program parameters or other factors that we determine may be further informed by comment from Kaiser Permanente. As determined necessary, we would submit comments through the regular public comment process after the extension request is filed with CMS. I'm aware the state filed a letter of intent to apply for a five-year extension of the program last fall, but I understand the extension application has not been filed.
As health care costs continue to rise, and as the state mitigates the risks and impacts of

H.R. 1, we understand the importance of partnership and creative approaches to challenges. We look forward to finding additional opportunities for collaboration with you and the department. Please reach out at any point for dialogue or partnership.

Wendy

Wendy Watson, MPH
"she/her/hers"
President
Kaiser Foundation Health Plan & Hospitals of the Northwest
500 NE Multnomah Street Portland, OR 97232

503.320.5998 (mobile phone)

kp.org/thrive

Exhibit 8 – Moda Health

February 25, 2026

TK Keen, Oregon Insurance Commissioner and DFR Administrator
Attention: Joel Payton, ORP Program Manager
350 Winter Street NE
Salem, OR 97301

Commissioner Keen,

Moda Health Plan, Inc. (Moda) is submitting this letter in support of Oregon's Department of Consumer and Business Services (DCBS) Section 1332 State Innovation Waiver allowing the state to implement a reinsurance program for a further five years for the period of 2028-2032.

Section 1332 of the Affordable Care Act (ACA) allows States to apply for an innovation waiver to creatively and effectively provide access to quality health care. The Oregon Reinsurance Program (ORP) created under this waiver has provided stability and flexibility to health insurance markets in Oregon. The program has helped health insurance companies like Moda cover the claims of high-cost enrollees, which in turn keep premiums 6% lower on average for Oregonians purchasing insurance in the individual market. The ORP annually reimburses insurers 50% of claims between $108,000 and $1,000,000 incurred by high-risk individuals which provides incentives for health insurance companies to remain in the individual market and offer broader plan choices for Oregonians.

Oregon's proposal to extend the ORP is a key component of long-term viability of the Oregon individual market for consumers and insurance companies alike. The OPR is particularly important at this time due to the disruption in the individual market caused by the enhanced premium tax credits not being renewed by Congress. Moda supports Oregon's 1332 State Innovation Waiver and urges the Departments to approve the requested five-year extension.

Sincerely,

Robert G. Gootee
President and CEO

Kraig E. Anderson
Senior Vice President and Chief Actuary

Health plans provided by Moda Health Plan, Inc.

PO Box 40384 Portland, Oregon 97240 | 800-852-5195 modahealth.com

Appendix 4 – Public Forums

Exhibit 9 – Invitation to Nine Federally Recognized Tribes of Oregon

DCBS | Department of Consumer and Business Services

OFFICE of TRIBAL AFFAIRS

OREGON HEALTH AUTHORITY

April 1, 2026

Dear Tribal Leader,

In an ongoing effort to consult with the Nine Federally Recognized Tribes of Oregon and confer with the Urban Indian Health Program on issues that may impact the Tribes and the health of their members, and in conjunction with the Oregon Health Authority as the Oregon Health Insurance Marketplace falls under its jurisdiction, this letter is to inform you of an identified critical event: **Oregon Reinsurance Program Application for a five-year extension of the Patient Protection and Affordable Care Act 1332 State Innovation and Empowerment Waiver (PPACA1332). The agencies do not believe the five-year extension of the ACA waiver will have any adverse impact on Indians, Indian health programs, or Urban Indian Organizations. We are sending this letter as required per our agency consultation policy and the CMS Consultation Policy.**

The Division of Financial Regulation, part of the Oregon Department of Consumer and Business Services (DCBS), is applying to the Centers for Medicare & Medicaid Services (CMS) for a five-year extension of the Patient Protection and Affordable Care Act 1332 State Innovation and Empowerment Waiver (ACA waiver). If granted, the ACA waiver will allow DCBS to continue the Oregon Reinsurance Program (ORP), which helps lower the cost of health insurance available on the Oregon Health Insurance Marketplace. The ORP has been in place since 2018, but will expire on December 31, 2027, without this waiver. Please review the current PPACA1332 Waiver attached with this letter from the U.S. Department of Health and Human Services and U.S. Department of Treasury.

If you would like to participate in a formal consultation/confer to discuss this topic, please let us know so that we can get it scheduled. If a formal consultation/confer is not needed, we invite you to provide any comments, suggestions, or questions to: Joel Payton, ORP Program Manager, joel.j.payton@dcbs.oregon.gov.

Kind regards,

TK Keen
Insurance Commissioner/DFR Administrator
Consumer and Business Services

Julie Johnson
Tribal Affairs Director Department of
Oregon Health Authority

350 Winter St. NE
P.O. Box 14480
Salem, OR 97309
503-378-4140 dfr.financialserviceshelp@dcbs.oregon.gov |
dfr.insurancehelp@dcbs.oregon.gov | dfr.oregon.gov

Exhibit 10 – SB 770 HHS Cluster Meeting October 6, 2025

Department of Consumer and Business Services
Oregon Reinsurance Program

SB 770 Health and Human Services Cluster meeting

Presenter: Joel Payton
Oregon Reinsurance Program manager

DFR | Division of Financial Regulation
Department of Consumer and Business Services

The Department of Consumer and Business Services

Oregon's largest business regulatory and consumer protection agency



DCBS Divisions

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

Oregon Reinsurance Program

Purpose

- Stabilize premium rates in individual health insurance market
- Reduce risk of high-cost claims for all insurance companies
- Expand health plan options throughout the state

Reinsurance Program overview

Program goals

- Reduce health insurance premium prices for Oregonians, including tribal members who buy insurance on the individual market.
  - Private plans with no out-of-pocket cost ($62,400 annual income family of four)*
- Expand healthcare services in every county throughout the state (five to six plan options per county)
  - According to OHIM 2025 enrollment averaged 900 tribal members
- Stabilize and strengthen Oregon's individual health insurance market

Source: * Health Care Coverage for American Indians and Alaska Natives | HealthCare.gov

Reinsurance Program overview

Original program authorization

- HB 2391 (2018) and Measure 101 premium assessment
- Patient Protection and Affordable Care Act (PPACA) §1332 State Relief and Empowerment Waiver 1/1/2018 *

Current program authorization

- HB 2010 (2025) extend the authority through 12/31/2032 **
- Federal §1332 Waiver operates through Winter 2027
  - DCBS will seek another 5-year Federal Waiver by late 2026.

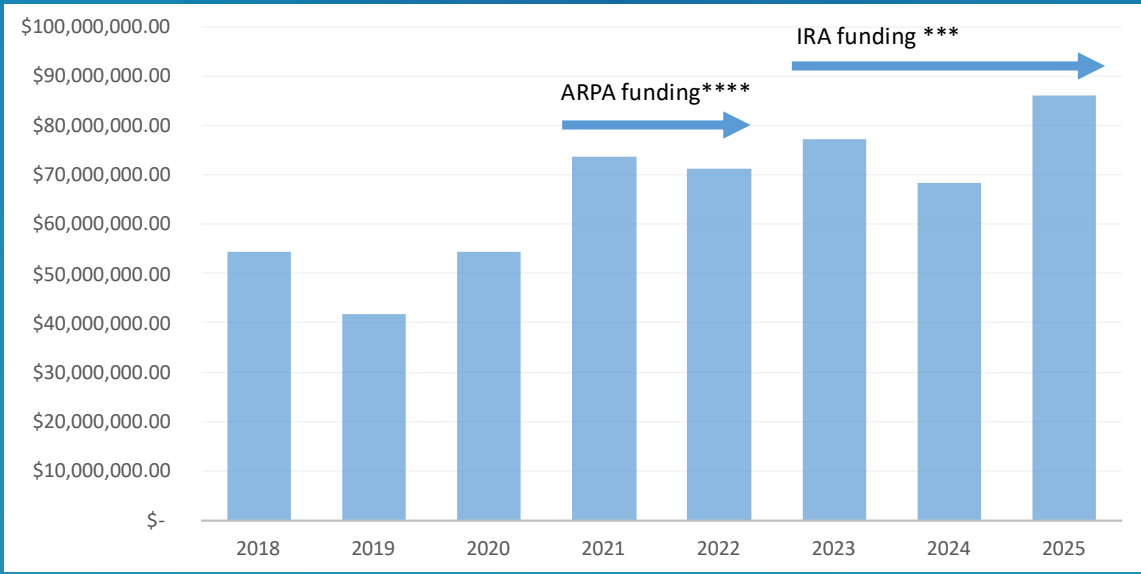
Sources:
* https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers
** https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/HB2010/Enrolled

Sources of funding for ORP



ORP is budget neutral for both the state and federal governments!

Oregon 1332 waiver pass-through funding



Benefits

- Both federal and state funding are used to assist consumers in providing affordable healthcare statewide including tribal communities
- Oregonians save at least 6.5 percent on healthcare premiums per year because of the ACA Waiver and ORP
- Expanded healthcare plan options throughout Oregon

Future discussions

- Department of Consumer and Business Services ACA Waiver Extension
- Waiver extension discussions planned for next year.

Address:
Oregon Department of Consumer and Business Services
Office of the Oregon Insurance Commissioner
350 Winter St. NE 2nd floor
Salem, Oregon, 97301

Questions?

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

DFR Division of Financial Regulation
Department of Consumer and Business Services

Exhibit 11 – Pass-through funding 2026 and Waiver extension

PPACA 1332
Waiver Extension 2028-2032

July 10, 2026
Time: 10:am

Presenter: Joel Payton, Reinsurance Program manager
Division of Financial Regulation

DFR | Division of Financial Regulation
Department of Consumer and Business Services

The Department of Consumer and Business Services

Oregon's largest business regulatory and consumer protection agency











DCBS divisions and programs

- Building Codes Division
- Division of Financial Regulation
- Oregon OSHA
- Workers' Compensation Division
- Workers' Compensation Board
- Management – Labor Advisory Committee
- Multi Cultural Communications Program
- OMBUDS Office for Oregon Workers
- Prescription Drug Affordability Board
- Small Business Ombudsman
- Universal Health Plan Governance Board
- Workers' Benefit Fund
- Workers' Compensation Division

Background – Federal

DCBS is currently approved to operate the Patient Protection and Affordable Care Act section 1332 State Innovation and Empowerment Waiver (ACA Waiver).

State Innovation Waivers have a five-year term limit.

DCBS approved waiver of the ACA requirement for the single risk pool contained in ACA section 1312(c)(1) allows Oregon to operate a state-based reinsurance program for the individual health insurance market from Jan. 1, 2023, through Dec. 31, 2027.

ACA Waivers are managed by the Centers for Consumer Information and Insurance Oversight.

ACA Waivers are approved by the U.S. Department of Health and Human Services and the U.S. Department of Treasury for 5 years.

Background – Oregon

House Bill 2010 (2025) gives Oregon's Department of Consumer and Business Services the authority to operate the Oregon Reinsurance Program, which helps lower cost of insurance premiums, expands cover options throughout Oregon, and covers a portion of a members high-cost health care claims from eligible health insurance companies.

Oregon's current (HB 2010) law operates Jan. 1, 2026, through Dec. 31, 2032.

Funding is derived from a 2 percent assessment on eligible hospitals, health care claims premiums on the commercial health insurance market, Oregon Public Employee Benefit Boards members, and stop-loss plans.

Federal waiver – Requirements

Coverage – five principles

1. Provide more affordable private market coverage
2. Encourage sustainable spending growth
3. Foster state innovation
4. Support and empower those in need
5. Promote consumer – driven health care

Federal waiver – Requirements

Five principles of sustainability

1. Foster state innovation
2. Provide more affordable private market coverage
3. Encourage sustainable spending growth
4. Promote consumer – driven healthcare
5. Support and empower those in need

Federal waiver – Requirements

State Innovation

Oregon Reinsurance Program HB2010 (2025)

What ? - Helps eligible health insures lower premium rates
How ? - ORP reimburse a portion of cost of high – cost healthcare claims with insurers
Why ? – Make health insurance more affordable and accessible for consumers

Section 1332: State Innovation Waivers

How does a section 1332 waiver help consumers afford health insurance?

1. Gives Oregon the authority to waive section 1312 (c) (1) Single risk pool
2. Gives Oregon the ability to implement a Reinsurance Program
3. Lower cost of health plan premiums and expand health plan options

Section 1332: State Innovation Waivers

How does a section 1332 waiver help consumers afford health insurance?

Single Risks Pool

Process were health insurers combined all their individual market enrollees together. This spreads the risk of high-cost patient healthcare claims across the entire population, preventing rate hikes for those with pre-existing conditions.

PPACA 1312 (c) (1) gives eligible states the authority to waive this option.

Section 1332: State Innovation Waivers

How does a section 1332 waiver help consumers afford health insurance?

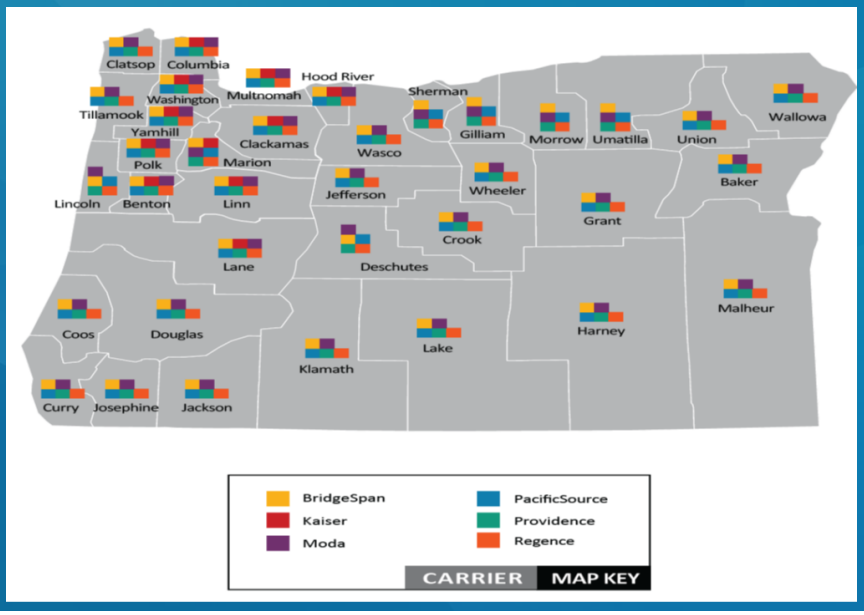
Why Oregon chose to waive the 'Single Risks Pool'(SRP)

- Fund state-based reinsurance program
- 1. Lower premiums: Reinsurance allows insurers to be compensated for catastrophic, high-costs claims, reducing overall premium rates across the state.
- 2. Recapture federal funds: Waiving the SRP reduces ACA premium tax credits. The federal government redirects these savings to the state via "pass-through" funding to help pay the high-cost claims.
- 3. Stabilize the health insurance market: Lower premiums encourage healthier individual to purchase insurance, which improves the overall balance of the SRP and keeps the market attractive to health insurers.

Federal waiver – Requirements

Affordable Market Coverage

5 to 6 plan options in 36 counties (2026)



Federal waiver — Requirements

Membership enrollment *

Year Q1	On exchange	Off exchange	ACA compliant	Total enrollment
2022	136,884	39,468	176,211	176,312
2023	133,230	35,763	168,896	168,993
2024	130,514	32,047	169,414	169,508
2025	130,514	30,746	161,180	161,260
2026**	107,018	32,786	139,730	139,804

I.Federal.Poverty.Level.(FPL).qualifying.members.for.individual.market.equals.766.to.066.percent;
II.Oregon.Benefit.Health.Plan.(HB.0690(8688)).FPL.equals.794to.866.percent - current.impact.to individual.market.enrollment

Federal Waiver - Requirements

Sustainable Spending Growth - Affordability

Year	Savings	Attachment points	Coinsurance rate	Cap
2022	$112,036,203.16	$92,000	50%	$ 1 million
2023	$103,763,380.80	$95,000	50%	$ 1 million
2024	$118,442,096.21	$95,000	50%	$ 1 million
2025	$121,000,000	$103,000	50%	$ 1 million
2026	$127,700,000	$108,000	50%	$ 1 million

Savings = total health care claims paid by the ORP for consumers who incur high-cost health care claims.

Federal waiver – Requirements

Support Consumer Healthcare – Comprehensive Health Plans

Oregon Health Insurance Marketplace essential health benefits

All Marketplace plans must cover 10 essential health benefits in the following categories:

- Ambulatory (outpatient) services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Federal waiver – Requirements

Support those in need - Federal Funding

Year	Pass-through funding	Allocated funds	Remaing balance
2022	$71,278,130	$55,000,000	$16,278,130.00
2023	$77,125,563	$60,037,707	$11,240,423.00
2024	$68,269,450	$60,037,516	$8,231,934.00
2025	$86,039,600	$86,992,825	$-953,225.00
2026	$65,410,716	$70,000,000 (Approx)	$29,797,262.00 [surplus]

I.Waivers.must.not.increase.the.federal.deficit.over.the.period.of.the.waiver; (PPACA ° 7998.waiver.guardrails.standard.terms.and.conditions)

Federal waiver – Requirements

Support those in need - State Funding

Year	Allocated funds **
2022	$52,800,000.00
2023	$43,725,673.00
2024	$49,766,753
2025	$31,449,271.21
2026	$32,000,000 est.

I. I. Totals are approximate pending State Audits

Federal waiver – Requirements

Pass Through Funding - 2026

Budget = $127,000,000
Federal Award = $65,410,716.00
State Obligation = $61,589,284

Federal Waiver extension period

Oregon's PPACA 1332 State Innovation and Empowerment Waiver timeline

DCBS	CMSCCIIO	Submission	CMS response
Letter of intent to extend ACA Waiver 9/2/2025	Responded 09/30/2025		
DCBS acknowledgement 10/01/2025		Estimated time-line to Submit to CMSCCIIO and HHD and Treasury 11/30/2026	Preliminary response to completion of application 30 days. Federal public comment period 30 pending completion of application

Oregon DCBS requested a five-year ACA waiver extension – Janu. 1, 2028, to Dec. 31,2032

Questions?

Public comment period open from July 10, 2026, to August 10, 2026

Contact information

Joel Payton, MPA, CA
503-302-4795
joel.j.payton@dcbs.oregon.gov
Division of Financial Regulation

Https://dfr.Oregon.gov/business/reg/health/Pages/Oregon-reinsurance-program.aspx

DFR | Division of Financial Regulation
Department of Consumer and Business Services

Appendix 5 – NovaRest actuarial report

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

September 2026

Table of Contents

Executive Summary 3
Waiver Program Operations and Annual Parameter Updates 4
Changes Affecting Prior Waiver Assumptions and Projections 5
Evaluation of the Oregon 1332 Waiver Reinsurance Program 7
Updates to Data Sources, Methodology, and Program Operations 11
Five-Year Projections 13
Meeting the Section 1332 Waiver Guardrails 18
Comprehensive Coverage 18
Affordability Requirement 18
Scope of Coverage Requirement 19
Deficit Neutrality Requirement 19
Limitations 20
Actuarial Certification 21
Appendix A - Data, Assumptions, and Methodology 23
Appendix B – Qualifications 29
About the Model Team 29

156 West Calle Guija, Suite 200, Sahuarita, AZ 85629 tel: 520-908-7246 - fax: 772-673-0318 NovaRest.com

I. Executive Summary

The Oregon Department of Business Services (DCBS) engaged NovaRest Actuarial Consulting (NovaRest) to develop the Actuarial and Economic Analysis[1] 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 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.

Oregon seeks a five-year extension of the approved 1332 Waiver for the Oregon Reinsurance Program (ORP) for plan years 2028 through 2032. Other than the extension, the ORP will continue to operate as it has since it became effective on January 1, 2018. The State is not requesting any substantive changes to the Waiver design. No amendment to the approved Waiver is requested.

The ORP would continue to provide payments to Oregon individual Affordable Care Act (ACA) market issuers for a portion of the claims of high-cost enrollees. The extended program will continue to be funded through a combination of state funding and federal pass-through funding. Any annual adjustments to program parameters will continue to be made consistent with the Waiver's specific terms and conditions (STCs). This report evaluates program experience since approval of the current Waiver extension and demonstrates that the proposed extension continues to satisfy the statutory guardrails.

This report evaluates program experience under the current Waiver, identifies changes affecting Waiver assumptions and projections since approval of the current extension, and demonstrates that the proposed extension continues to satisfy the statutory requirements of Section 1332, including the scope of coverage, affordability, comprehensiveness, and federal deficit neutrality guardrails.

[1] Based on December 9, 2024 Updated Checklist for Section 1332 Waiver Applications: initial applications, extensions, and amendments available at https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers. Accessed June 7, 2026.

II. Waiver Program Operations and Annual Parameter Updates

The ORP reimburses individual ACA market health insurers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). The program functions in a manner similar to that of the ACA Federal Transitional Reinsurance program. NovaRest refers to the combined design elements of attachment point, coinsurance, and reinsurance cap as the "ORP reinsurance parameters."

Since approval of the current Waiver extension, Oregon has continued to make annual adjustments to ORP reinsurance parameters to achieve a target total reinsurance dollar amount consistent with a target estimated premium reduction between the Without 1332 Waiver (Baseline) scenario compared to the With 1332 Waiver scenario. These adjustments will continue to be made consistent with the Waiver's STCs and are made to reflect emerging market conditions, medical cost trends, enrollment changes, and available funding. Such adjustments do not alter the fundamental design or objectives of the Waiver.

Table 1 details the ORP reinsurance parameters for each year since the implementation of the ORP.

Table 1 ORP Reinsurance Parameters

Calendar Year	Attachment Point	Coinsurance	Reinsurance Cap
2018	$95,000	59%	$1 million
2019	$90,000	50%	$1 million
2020	$90,000	50%	$1 million
2021	$90,000	50%	$1 million
2022	$92,000	50%	$1 million
2023	$95,000	50%	$1 million
2024	$95,000	50%	$1 million
2025	$103,000	50%	$1 million
2026	$108,000	50%	$1 million
2027	$131,000	50%	$1 million

Changes Affecting Prior Waiver Assumptions and Projections

Oregon's Initial Waiver was approved in 2017, for the January 1, 2018, through December 31, 2022 effective period. Oregon's Waiver Extension Request was approved in 2022, for the January 1, 2023 through December 31, 2027 effective period.

While the ORP has operated without substantive changes since approval of the current Waiver extension, actual market experience has been influenced by several developments that were not anticipated when the extension projections were prepared.

Enhanced Advanced Premium Tax Credits (eAPTCs) –

The American Rescue Plan Act (ARPA) introduced significantly increased premium subsidies (eAPTCs) which were set to expire at the end of 2022. The prior 2022 Waiver Extension Request actuarial analysis assumed the eAPTCs would expire as expected. However, after approval of the prior 2022 Waiver Extension Request, the Inflation Reduction Act (IRA) extended the eAPTCs through 2025.

The eAPTC generally increased the subsidized population, increasing the federal pass-through above expectations made in the prior Waiver Extension Request actuarial analysis.

Medicaid Unwinding-

With the end of the COVID-19 Public Health Emergency (PHE), there was an explanation that Medicaid enrollees would re-join the Oregon individual ACA market.

The prior 2022 Waiver Extension Request actuarial analysis did not make an explicit adjustment to membership, however, Medicaid Unwinding and the eAPTCs were complicating factors in enrollment and premium projections.

Oregon Health Plan (OHP) Bridge

The OHP Bridge is a health coverage benefit introduced in Oregon in 2024. Eligibility for the OHP Bridge includes adults under age 65 with annual income between 133 and 200 percent of the federal poverty level (FPL).[2]

The OHP Bridge was not anticipated in the prior 2022 Waiver Extension Request actuarial analysis.

The OHP Bridge likely attracted membership from the Oregon individual ACA market, reducing enrollment (including subsidized enrollment), premiums and federal pass-through funding.

Medical Cost and Premium Trends

All of the above factors also impacted expectations regarding the underlying risk pool in the Oregon individual ACA market. In addition, recent rate filings in Oregon have indicated significantly higher cost trends than anticipated in the prior 2022 Waiver Extension Request actuarial analysis, resulting in higher premium rate increases, lower enrollment, and higher federal pass-through.

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[2] Oregon Health Plan (OHP) Bridge. Oregon Health Authority. https://www.oregon.gov/oha/hsd/ohp/pages/bridge.aspx. Accessed June 7, 2026.

IV. Evaluation of the Oregon 1332 Waiver Reinsurance Program

The following Tables show projections compared to observable outcomes. Years 2018 to 2022 reflect projections from the 2017 Initial Waiver Application,[3] while years 2023 to 2027 reflect projections from the previous 2022 Waiver Extension Request.[4]

Actual results are generally based on State Innovation Waiver Reinsurance Annual Reporting for the 2018-2024 period (the most recent currently available). 2025 and 2026 are preliminary based on January data received by carriers via a data call.[5]

Table 2 Comparison of Projected and Actual Oregon Individual ACA (Non-Group) Enrollment

Calendar Year	Projected With 1332 Waiver	Actual (With 1332 Waiver)	Actual to Projected %
2018	204,162	191,556	94%
2019	203,924	177,201	87%
2020	203,666	174,746	86%
2021	203,666	172,365	85%
2022	203,666	169,075	83%
2023	174,023	162,895	94%
2024	170,492	165,123	97%
2025	168,027	156,364	93%
2026	165,592	142,177*	86%
2027	163,239		

* Preliminary based on January data received by carriers via a data call, as opposed to average annual.

Actual enrollment has been below projected With 1332 Waiver enrollment due to a variety of factors as discussed above including market reaction to higher premium increases than anticipated, as well as the OHP Bridge and expiration of eAPTCs. However, we believe enrollment would be significantly lower Without 1332 Waiver due to enrollee price sensitivity.

For example, 2025 to 2026 shows a significant drop in membership, likely due to the expiration of the eAPTCs driving higher premium increases and causing price sensitive members to seek alternate coverage such as OHP Bridge or go uninsured.

[redacted]

[3] "Oregon 1332 Draft Waiver Application." August 31, 2017.

[4] "Oregon 1332 State Innovation Waiver Five-Year Extension Application State Reinsurance Program." July 1, 2022. https://dfr.oregon.gov/business/reg/health/Documents/reinsurance-program/innovation-waiver-2023-2027-

app.pdf. Accessed June 7, 2026.

[5] Actual results from State Innovation Waiver Reinsurance Annual Reports for 2018-2024. Average annual PMPMs are weighted on-exchange and off-exchange. https://dfr.oregon.gov/business/reg/health/pages/oregon-reinsurance-program.aspx. 2025-2026 preliminary estimates from January 2026 snapshot provided via carrier data call.

Table 3 Comparison of Projected and Actual Oregon Individual ACA (Non-Group) Average Premium PMPM					
Calendar Year	Projected Without 1332 Waiver	Projected With 1332 Waiver	Actual (With 1332 Waiver)	Actual to Projected Without Waiver %	Actual to Projected With Waiver %
2018	$508	$470	$492	97%	105%
2019	$530	$493	$542	102%	110%
2020	$551	$516	$566	103%	110%
2021	$578	$541	$536	93%	99%
2022	$568	$607	$575	101%	95%
2023	$659	$604	$609	92%	101%
2024	$699	$641	$648	93%	101%
2025	$730	$669	$672	92%	100%
2026	$763	$700	$727*	95%	104%
2027	$798	$732			

* Preliminary based on January data received by carriers via a data call, as opposed to average annual.

Actual average premium PMPMs have been relatively consistent with the projected With 1332 Waiver scenario from the previous 2022 Waiver Extension Request. Higher than expected rate increases in 2026 caused the actual premium PMPM to deviate more than prior years. However, we note that generally actual premiums have been below the projected Without 1332 Waiver scenario demonstrating that the ORP has succeeded in reducing average premiums.

[redacted]

Table 4 Comparison of Projected and Actual ORP Total Reinsurance Dollars			
Calendar Year	Projected	Actual	Actual to Projected %
2018	$90,000,000	$90,000,000	100%
2019	$95,000,000	$94,500,000	99%
2020	$99,465,000	$96,600,000	97%
2021	$104,338,785	$112,155,180	107%
2022	$109,555,724	$103,763,381	95%
2023	$113,299,972	$112,036,203	99%
2024	$120,097,971	$118,442,096	99%
2025	$125,382,281	$131,042,674	105%
2026	$131,024,484		
2027	$136,920,586		

Total actual ORP reinsurance dollar estimations have been relatively close to projected. As discussed above, ORP reinsurance parameters are reconsidered annually to achieve a target total dollar amount corresponding to a target premium reduction. We believe the 2021 under projection was driven by COVID-19 pandemic, and 2025 appears to be driven by an unexpected but significant increase in high-cost claims.

Table 5 Comparison of Projected and Actual[6] Federal Pass-Through			
Calendar Year	Projected	Actual	Actual to Projected %
2018	$32,866,704	$54,482,113	166%
2019	$32,021,529	$41,845,226	131%
2020	$30,704,066	$54,408,157	177%
2021	$32,117,894	$73,723,375	230%
2022	$33,745,048	$71,278,130	211%
2023	$54,733,838	$77,125,563	141%
2024	$58,014,787	$68,269,450	118%
2025	$60,564,940	$86,039,600	142%
2026	$63,287,608	$65,410,716	103%
2027	$66,132,596		

Actual federal pass-through funding has exceeded original projections since the implementation of the ORP. A significant contributor to this difference was the introduction of the enhanced eAPTCs in 2021, which substantially increased the number of subsidized enrollees. While the projections included in the 2022 Waiver Extension Request represented a material improvement over the initial Waiver projections, those estimates assumed that the eAPTCs would expire after 2022, consistent with federal law at the time. The eAPTCs were extended through 2025, which is a primary driver of under-projecting federal pass-through dollars through 2025. We note that 2026 federal pass-through dollars, after the expiration of the eAPTCs, was very close to 2022 Waiver Extension Request projections.

[redacted]

[6] Actual federal pass-through amounts published by CMS available at https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers. Accessed August 3, 2026.

Updates to Data Sources, Methodology, and Program Operations

NovaRest's underlying methodology has not changed significantly from Oregon's previous 2022 Waiver Extension Request actuarial analysis except as described in this section. Appendix A includes a description of the data, assumptions, and methodology used by NovaRest.

Updated Experience Data

NovaRest receives updated claims and enrollment data from Oregon individual ACA carriers annually.

NovaRest also received updated reinsurance dollar spend and enrollment information from Oregon.

Additionally, public sources used such as Oregon individual ACA carrier rate filings, Marketplace Open Enrollment Period Public Use Files, commercial trend studies and National Health Expenditure (NHE) data have been updated.

In the prior analysis NHE trends were relied upon for all years where carrier proposed trends or premium rate increases were not available to project claims and premiums. However, we believe NHE trends have been low in recent years when considering actual experience, carrier rate filings, and industry studies. For example, in the 2022 Waiver Extension Request projections the NHE trends from 2025 to 2027 were approximately 4% annually while actual rate increases were approximately 12% annually over the same period. Similarly, the most recent actual claims from 2023 to 2025 show trends at about 14% annually. Therefore, we are using a different methodology to project claims and premiums.

To project total reinsured claim dollars, we note that Oregon updates the ORP reinsurance parameters annually to meet a target premium reduction, which DCBS estimates as a total reinsurance dollar increase of approximately $15 million annually.[7] Therefore, reinsurance dollars are projected by increasing at $15 million annually, except for 2027 to 2029 where we estimate some reduction in total reinsurance dollars as eligible members exit for the OHP Bridge. While NovaRest did not develop this estimate, we reviewed the resulting increase in reinsured claims per member and believe it is not unreasonable considering actual Oregon reinsured claim trends and carrier premium rate increases.

[7] DCBS provided via email dated 7/27/2026.

For premiums, we believe recent premium rate increases have been elevated by the expiration of the eAPTCs, however, we note that Oregon carriers are still projecting claims increases of 8.1% annually on average, which is supported by industry studies. Therefore, we are assuming premiums rate increases of 8.1% annually.

Expiration of eAPTCs

Modelling from Oregon's previous 2022 Waiver Extension Request actuarial analysis assumed eAPTCs would expire at the end of 2022, consistent with federal law at the time. Modelling adjustments were therefore made to convert underlying data based on eAPTCs to convert to pre-eAPTC subsidies.

In this analysis, we are starting with 2026 enrollment, APTC, and premium information, which is not based on eAPTCs.

While claims information is starting with 2025 claims NovaRest did not make an adjustment to the claims due to the expiration of the eAPTCs. NovaRest did identify a decrease in enrollment from 2025 to 2026 as a result of the expiration of the eAPTCs, however, we assume those that left the market due to the expiration of the eAPTCs did not incur sufficient claims to meet the ORP attachment point.

OHP Bridge

Oregon's previous 2022 Waiver Extension Request did not anticipate the implementation of the OHP Bridge.

A detailed explanation is included in Appendix A, however, NovaRest adjusted enrollment, premiums, reinsurance claims, and federal pass-through to account for eligible members moving to the OHP Bridge.

State-Based Exchange (SBE)

Oregon is expected to become a full SBE in 2026.

This has the effect of accelerating the transition of members to the OHP Bridge in NovaRest's modelling, as the SBE is expected to begin the process of redetermining members when it becomes effective.

NovaRest expects Oregon will complete the transition from a State-Based Exchange on the federal platform (SBE-FP) to a full SBE prior to 2028. Therefore, projections no longer consider Exchange User Fees as a loss of federal revenues in the pass-through analysis.

VI. Five-Year Projections

To develop the projections from 2028-2032, we used the process and assumptions described above. The tables below show the membership and premiums for 2028-2032 for both the Without 1332 Waiver (Baseline) and With 1332 Waiver scenario under which the extension is not approved. The assumptions used include movement to the OHP Bridge, with only about 200 OHP Bridge eligible members remaining in the Oregon individual ACA market in 2028, and 0 in 2029 and beyond.

Tables 6 and 7 contain the 5-year projections (2028 through 2032) for the Without 1332 Waiver (Baseline) scenario and the With 1332 Waiver scenario respectively, while Table 8 provides a comparison of average premium and enrollment. As discussed above, Oregon reassesses the ORP reinsurance parameters annually. For the projections, NovaRest did not vary the ORP reinsurance parameters.

Table 6 2028-2032 Without 1332 Waiver (Baseline)					
Membership	2028	2029	2030	2031	2032
100% CSR	750	750	750	750	750
94% CSR	86	0	0	0	0
87% CSR	108	0	0	0	0
73% CSR	8,676	8,676	8,676	8,676	8,676
APTC Non-CSR	44,582	44,550	44,550	44,550	44,550
Total APTC	54,201	53,976	53,976	53,976	53,976
Total Non-APTC	27,404	25,139	23,054	21,135	19,369
Total On-Exchange	81,605	79,116	77,030	75,111	73,346
Off Exchange	28,671	27,810	26,941	26,065	25,185
Total Non-Group ACA	110,276	106,926	103,971	101,176	98,531
Average Premium PMPM					
APTC Agg Prem	$1,144	$1,236	$1,336	$1,445	$1,562
APTC Net Prem	$312	$327	$341	$356	$371
APTC[8]	$829	$907	$992	$1,086	$1,187
Non-APTC	$923	$998	$1,079	$1,167	$1,262
Total On-Exchange	$1,070	$1,161	$1,259	$1,366	$1,482
Off Exchange	$957	$1,034	$1,116	$1,206	$1,302
Total Non-Group ACA	$1,040	$1,128	$1,222	$1,325	$1,436
Total Annual Premium					
Total APTC Agg Prem	$743,791,323	$800,682,405	$865,537,679	$935,646,231	$1,011,433,576
Total APTC Net Prem	$203,141,166	$211,545,632	$220,814,439	$230,489,355	$240,588,175
Total APTC[8]	$539,036,957	$587,400,183	$642,845,987	$703,127,565	$768,651,716
Total Non-APTC	$303,632,121	$301,143,642	$298,602,921	$296,000,890	$293,346,227
Total On Exchange	$1,047,423,443	$1,101,826,047	$1,164,140,600	$1,231,647,122	$1,304,779,803
Off Exchange	$329,354,280	$344,999,641	$360,943,479	$377,161,410	$393,630,568
Total Non-Group ACA	$1,376,777,723	$1,446,825,688	$1,525,084,079	$1,608,808,531	$1,698,410,371

[8] APTC is calculated on EHB benefits only, while premium projections reflect a small amount of non-EHB benefits.

Table 7 2028-2032 With 1332 Waiver					
Membership	2028	2029	2030	2031	2032
100% CSR	750	750	750	750	750
94% CSR	86	0	0	0	0
87% CSR	108	0	0	0	0
73% CSR	8,676	8,676	8,676	8,676	8,676
APTC Non-CSR	44,582	44,550	44,550	44,550	44,550
Total APTC	54,201	53,976	53,976	53,976	53,976
Total Non-APTC	32,732	30,064	27,601	25,329	23,236
Total On-Exchange	86,934	84,040	81,577	79,306	77,212
Off Exchange	30,151	29,275	28,396	27,513	26,628
Total Non-Group ACA	117,085	113,315	109,973	106,818	103,840
Average Premium PMPM					
APTC Agg Prem	$1,035	$1,119	$1,209	$1,307	$1,413
APTC Net Prem	$312	$327	$341	$356	$371
APTC[9]	$720	$790	$866	$949	$1,039
Non-APTC	$836	$903	$977	$1,056	$1,142
Total On-Exchange	$960	$1,042	$1,131	$1,227	$1,332
Off Exchange	$868	$937	$1,012	$1,093	$1,181
Total Non-Group ACA	$936	$1,015	$1,100	$1,193	$1,293
Total Annual Premium					
Total APTC Agg Prem	$673,189,052	$724,689,542	$783,389,394	$846,843,935	$915,438,294
Total APTC Net Prem	$203,141,166	$211,545,632	$220,814,439	$230,489,355	$240,588,175
Total APTC[9]	$468,576,445	$511,559,900	$560,862,642	$614,503,569	$672,849,176
Total Non-APTC	$328,198,797	$325,856,285	$323,426,921	$320,902,236	$318,293,235
Total On Exchange	$1,001,387,849	$1,050,545,826	$1,106,816,316	$1,167,746,171	$1,233,731,529
Off Exchange	$314,051,865	$329,287,106	$344,924,023	$360,931,867	$377,281,735
Total Non-Group ACA	$1,315,439,715	$1,379,832,932	$1,451,740,339	$1,528,678,038	$1,611,013,264

[9] APTC is calculated on EHB benefits only, while premium projections reflect a small amount of non-EHB benefits.

Table 8 shows a 5-year (2028-2032) projection of non-group membership and non-group average premiums which demonstrate that we expect approximately 6% higher enrollment and 10% lower average premiums PMPM for the With 1332 Waiver scenario compared to Without 1332 Waiver.

Table 8 **2028-2032 Total Non-Group ACA Enrollment and Average Premium PMPM**					
Membership	2028	2029	2030	2031	2032
Total Non-Group ACA Without 1332 Waiver (Baseline)	110,276	106,926	103,971	101,176	98,531
Total Non-Group ACA With 1332 Waiver	117,085	113,315	109,973	106,818	103,840
Difference from Baseline (Number)	6,808	6,389	6,002	5,643	5,309
Difference from Baseline (%)	6.2%	6.0%	5.8%	5.6%	5.4%
Average Premium PMPM					
Total Non-Group ACA Without 1332 Waiver (Baseline)	$1,040	$1,128	$1,222	$1,325	$1,436
Total Non-Group ACA With 1332 Waiver	$936	$1,015	$1,100	$1,193	$1,293
Difference from Baseline (Number)	-$104	-$113	-$122	-$133	-$144
Difference from Baseline (%)	-10%	-10%	-10%	-10%	-10%

Table 9 provides the statewide average second lowest cost silver plan (SLCSP) at age 21, for the Without 1332 Waiver (Baseline) scenario and the With 1332 Waiver scenario. The statewide average SLCSP is the age 21 SLCSP by rating area, weighted enrollees in each area.

Table 9 **2028-2032 Age 21 State Average SLCSP**					
Age 21 State Average SLCSP	2028	2029	2030	2031	2032
Total Non-Group ACA Without 1332 Waiver (Baseline)	$595	$643	$695	$752	$812
Total Non-Group ACA With 1332 Waiver	$538	$582	$629	$680	$735
Difference from Baseline (Number)	-$56	-$61	-$66	-$71	-$77
Difference from Baseline (%)	-9.5%	-9.5%	-9.5%	-9.5%	-9.5%

Table 10 shows the development of the projected PTC savings, Oregon funding, and total ORP reinsurance dollars for years 2028 through 2032. Consistent with Oregon's previous 2022 Waiver Extension Request actuarial analysis, PTC is estimated as 95% of APTCs based on recent historic ratios published by the IRS,[10,11]

Table 10 Budget Neutrality Projection, 2028-2032					
Without 1332 Waiver (Baseline)	2028	2029	2030	2031	2032
APTC Agg Prem	$743,791,323	$800,682,405	$865,537,679	$935,646,231	$1,011,433,576
APTC Agg Prem (EHB Only)	$742,178,123	$798,945,815	$863,660,426	$933,616,920	$1,009,239,891
APTC Net Prem	$203,141,166	$211,545,632	$220,814,439	$230,489,355	$240,588,175
Total APTC	$539,036,957	$587,400,183	$642,845,987	$703,127,565	$768,651,716
Total PTC	$512,085,109	$558,030,173	$610,703,688	$667,971,187	$730,219,130
With 1332 Waiver					
APTC Agg Prem	$673,189,052	$724,689,542	$783,389,394	$846,843,935	$915,438,294
APTC Agg Prem (EHB Only)	$671,717,612	$723,105,532	$781,677,080	$844,992,924	$913,437,351
APTC Net Prem	$203,141,166	$211,545,632	$220,814,439	$230,489,355	$240,588,175
Total APTC	$468,576,445	$511,559,900	$560,862,642	$614,503,569	$672,849,176
Total PTC	$445,147,623	$485,981,905	$532,819,510	$583,778,390	$639,206,717
PTC Savings (federal pass-through)	$66,937,486	$72,048,268	$77,884,178	$84,192,797	$91,012,413
Oregon Funding	$78,607,716	$86,652,838	$95,816,929	$104,508,310	$112,688,694
Total Reinsurance	$145,545,202	$158,701,107	$173,701,107	$188,701,107	$203,701,107

[10] Health Insurance Premium Tax Credit and Cost-Sharing Reductions. Congressional Research Service. Updated February 19, 2026. Health Insurance Premium Tax Credit and Cost-Sharing Reductions

[11] Statistics of Income 2022 IRS Individual Income Tax Returns Complete Report,

Figure G. Internal Revenue Service. https://www.irs.gov/pub/irs-pdf/p1304.pdf. The PTC as a % of APTC varied from 97% in 2021 to 88% in 2022. Therefore, we did not change the assumption of 95% from the prior extension application.

VII. Meeting the Section 1332 Waiver Guardrails

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

Comprehensive Coverage[12]

A section 1332 waiver complies with the comprehensiveness guardrail if coverage under the waiver is forecast to be at least as comprehensive for residents of the State in the aggregate as coverage absent the waiver. Comprehensiveness refers to the scope of benefits provided by health coverage and is measured by the extent to which coverage meets the essential health benefits (EHB) requirements as defined in section 1302(b) of the ACA, aligns with the scope of benefits of health plans offered through the State's Exchanges or, as appropriate, Medicaid, or Children's Health Insurance Program (CHIP) standards.

The proposed 1332 Waiver extension does not modify covered benefits, eligibility requirements, actuarial value requirements, EHBs, or other benefit design standards applicable to individual market coverage. As a result, the 1332 Waiver does not alter the scope of benefits available to Oregon consumers during the proposed extension period (2028–2032).

Additionally, NovaRest believes the proposed 1332 Waiver extension will continue to result in a projected higher number of individuals with coverage that meets the ACA's EHB requirements with the 1332 Waiver, compared to projections Without 1332 Waiver (Baseline), as shown in Table 8.

Affordability Requirement[13]

A section 1332 waiver complies with the affordability guardrail if healthcare coverage under the waiver is forecast to be as affordable overall for State residents as coverage absent the waiver, in the aggregate.

The proposed 1332 Waiver extension will continue to improve affordability for Oregon consumers by reducing individual market premiums. NovaRest estimates the proposed 1332 Waiver extension will reduce average premiums PMPM by approximately 10% in each year from 2028 through 2032 relative to the projected Without 1332 Waiver scenario, as shown in Table 8.

[12] 45 C.F.R. § 155.1308(f)(3)(iv)(A)
[13] 45 C.F.R. § 155.1308(f)(3)(iv)(B)

Lower premiums reduce both consumer premium obligations and federal premium tax credit expenditures, improving affordability for subsidized and unsubsidized enrollees. Accordingly, NovaRest projects that coverage under the proposed 1332 Waiver extension will remain at least as affordable as coverage for the Without 1332 Waiver scenario throughout the extension period.

Scope of Coverage Requirement[14]

A section 1332 waiver complies with the coverage guardrail if a comparable number of State residents are forecast to have coverage under the section 1332 State plan as would have had coverage absent the waiver. Coverage refers to Minimum Essential Coverage (MEC) as defined in 26 U.S.C. 5000A(f) and "comparable" means that the forecasted number of covered individuals under the waiver is no less than absent the waiver.

NovaRest projects that the proposed Waiver extension will result in a greater number of individuals with health insurance coverage relative to the projected Without 1332 Waiver scenario, as shown in Table 8, for each year of the extension period (2028–2032). The projected increase in enrollment is primarily attributable to lower premiums resulting from the ORP. Accordingly, NovaRest projects that the 1332 Waiver will continue to satisfy the coverage guardrail throughout the extension period.

Deficit Neutrality Requirement[15]

A section 1332 waiver complies with the deficit neutrality guardrail if the projected Federal spending net of Federal revenues under the waiver is equal to or lower than projected Federal spending net of Federal revenues absent the waiver.

NovaRest projects that the proposed 1332 Waiver extension will satisfy the federal deficit neutrality guardrail throughout the extension period (2028–2032). The ORP reduces individual market premiums, resulting in lower federal PTC expenditures than would occur in the Without 1332 Waiver scenario. Under Section 1332, these federal savings are provided to Oregon as pass-through funding to support reinsurance payments.

Table 9 presents NovaRest's projected reductions in SLCSP premiums resulting from the Waiver. These premium reductions generate federal savings through lower PTC expenditures. NovaRest projects that pass-through funding will not exceed the federal savings attributable to the proposed 1332 Waiver in any year of the extension period. Accordingly, projected federal spending net of federal revenues under the proposed 1332 Waiver extension is not expected to exceed projected federal spending net of federal revenues for the Without 1332 Waiver scenario.

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[14] 45 C.F.R. § 155.1308(f)(3)(iv)(C)

[15] 45 C.F.R. § 155.1308(f)(3)(iv)(D), 45 C.F.R. § 155.1308(f)(4)(i)(iii)

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 to other potential reasonable assumptions 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 may vary from those assumed.

Additional limitations and considerations include:

2025 incurred claims data paid through January 2026 is from a carrier data call. We apply an IBNR assumption based on historical experience and run-out patterns identified from reviewing carrier data calls, carrier rate filings, and Oregon All Payer All Claims database, however, we did not perform an independent IBNR analysis for this assumption. Additionally, payment patterns are likely to vary by carrier.

Assumed trends are based on carrier rate filings, commercial trend studies, and NHE data and not from an independent study. Actual claims trends may vary.

The data that NovaRest used for membership and premium were snap shots as of January 2026. This may vary from actual 2026 results due to migration from/to the market.

Oregon updates the ORP reinsurance parameters annually. Currently we only know the ORP reinsurance parameters for 2027. NovaRest projections do not adjust the ORP reinsurance parameters, though we estimate total reinsurance dollars as increasing $15 million annually, estimated by DCBS as the amount needed to continue to achieve the target premium reduction.

NovaRest had little information on individuals eligible for 100% CSR (there are 750 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.

NovaRest assumed that grandfathered plan enrollees would continue to purchase grandfathered coverage, and we have not assumed migration of these enrollees into the ACA market.

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.

Actuarial Certification

Reliance

In the analysis described in this report, we relied on information provided by DCBS, the Oregon Health Authority, 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 2026.

We relied upon this information without independent audit or verification. We reviewed the data for reasonableness and consistency and, where appropriate, requested clarification regarding data anomalies or apparent inconsistencies. The data and information provided were reviewed for reasonableness and consistency with the intended use of this analysis. 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

To the best of our knowledge, there are no subsequent events occurring after the completion of this analysis that materially affect the results presented in this report.

Potential future developments that could affect future projections include continuation of eAPTCs, changes to federal funding of cost-sharing reductions, significant modifications to the OHP Bridge, or other material federal or state policy changes.

ASOPS

In performing this analysis, NovaRest applied generally accepted actuarial principles and practices and complied with applicable Actuarial Standards of Practice (ASOPs), including:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communications

ASOP No. 56, Modeling

Actuarial Certification

I, Richard Cadwell, ASA, MAAA, am the actuary responsible for the analysis and conclusions presented in this report. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

This report has been prepared solely to support Oregon's application for extension of its approved Section 1332 State Innovation Waiver. The intended users of this report are the Oregon Department of Consumer and Business Services, the Oregon Health Authority, CMS, the U.S. Department of the Treasury, and other federal agencies involved in the review of the Waiver extension application. 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 under the 1332 Waiver is forecast to be at least as comprehensive for residents of Oregon in the aggregate as coverage absent the 1332 Waiver.

The healthcare coverage under the 1332 Waiver is forecast to be as affordable overall for Oregon residents as coverage absent the 1332 Waiver, in the aggregate.

A comparable number of Oregon residents are forecast to have coverage under the 1332 Waiver as would have had coverage absent the 1332 Waiver

The projected Federal spending net of Federal revenues under the 1332 Waiver is equal to or lower than projected Federal spending net of Federal revenues absent the 1332 Waiver.

If you have any questions, do not hesitate to call Richard at (847) 973-2292.

Sincerely,



Richard Cadwell, ASA, MAAA



Appendix A - Data, Assumptions, and Methodology

The data used by NovaRest is generally consistent with the data sources used in the previous 2022 Waiver Extension Request, updated for more recent information.

Data call information received from individual ACA market issuers in Oregon, to collect January 2026 enrollment and premium information, as well as 2025 annual claim information paid through January 2026.

NovaRest performs a similar data call annually, and therefore has received similar data since 2021.

Oregon DCBS also provided internal reinsurance claim tracking reports for 2018 through 2025.

Additionally, NovaRest has collected public information including rate filing information in Oregon.

Claim and Premium Projections

The 2025 incurred claims data that we received only included one month of run-out (paid through January 2026). We applied an adjustment for incurred but not reported (IBNR) to 2025 paid claims of 11%, informed by recent DCBS internal reinsurance claim tracking reports. This assumption is higher than the prior extension application, as we discovered run-out from reinsurance eligible claims is materially higher than total claims. This is reassessed annually as part of ORP's annual parameter setting process.

Claims data was trended to 2027 using average trend assumptions from plan year 2027 Oregon individual ACA rate filings.

Reinsurance dollars are based on trended claims compared against the ORP reinsurance parameters for plan year 2027. To project total reinsured claim dollars, we note that Oregon updates the ORP reinsurance parameters annually to meet a target premium reduction, which DCBS estimates as a total reinsurance dollar increase of approximately $15 million annually.[16] Therefore, reinsurance dollars are projected by increasing at $15 million annually, except for 2027 to 2029 where we estimate some reduction in total reinsurance dollars as eligible members exit for the OHP Bridge. While NovaRest did not develop this estimate, we reviewed the resulting increase in reinsured claims per member and believe it is not unreasonable considering actual Oregon reinsured claim trends and carrier premium rate increases.

NovaRest did not make an adjustment to the claims due to the expiration of the eAPTCs. While NovaRest did identify a decrease in enrollment from 2025 to 2026 as a result of the expiration of the eAPTCs, we assume those that the individuals who would leave the market due to the expiration of the eAPTCs do not incur sufficient claims to meet the reinsurance program's attachment point.[17]

As premiums received and membership are from 2026, we did not make an adjustment due to the expiration of the eATPCs. We assume PMPM average premium increases by 8.1% annually are consistent with the most recent carrier estimates for claims trends, for the With 1332 Waiver scenario. The determination of the Without 1332 Waiver (Baseline) scenario is also adjusted by the ORP as a percentage of premium as discussed further below. We assume the SLCSP increases consistently with average premium increases. APTC and SLCSP dollars are estimated by removing any impact of non-EHBs by comparing plan information to assumed non-EHB impact in carrier rate filings.

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[16] DCBS provided via email dated 7/27/2026.

[17] Those with sufficient claims to meet the ORP attachment point are receiving significant value from their health plan from cost sharing that significantly outweighs the additional premium they would pay from the reduction of eAPTC.

Membership Projections

Individuals that were eligible for 100% CSR, 94% CSR, 87% CSR, 73% CSR and those receiving APTC without enrolling in a CSR plan (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 going forward, which is consistent with the previous 2022 Waiver Extension Request.

For all other individuals NovaRest used the elasticity by metal level presented at a Society of Actuaries (SOA) training session.[18] The elasticity estimates the percentage of membership that will reduce coverage (buy-down) based on the percent of PMPM average premium increases. We assume (consistent with the previous 2022 Waiver Extension Request):

individuals who buy-down will only reduce by one metal level at a time, i.e. Gold to Silver, Silver to Bronze, Bronze to uninsured,

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.[19] 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.

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.

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[18] 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.

[19] We note Oregon does not have any enrollees in Platinum or Catastrophic plans as of January 2026, therefore projections to not reflect any membership in these metal tiers.

Adjustments due to Oregon Health Plan (OHP) Bridge and Oregon Transition to a State-Based Exchange (SBE)

The OHP Bridge[20] became effective in 2024 and Oregon will transition from an SBE-FP to an SBE (Oregon Marketplace) in 2026. Neither of these were not considered in the previous 2022 Waiver Extension Request projections as NovaRest was unaware of these transitions at that time.

For the 2028 to 2032 projections, however, we did adjust claims, membership, and premiums to consider the impact of these transitions, where applicable.

Adults with incomes between 133 and 200 percent of the FPL are eligible for insurance through the OHP Bridge, which we expect will reduce membership in the Oregon individual ACA market. Our understanding is that consumers who complete a new Oregon Marketplace application within the appropriate income levels will be reviewed for eligibility. If found eligible, an Oregon Marketplace enrollee would no longer be eligible for a PTC in the Oregon Marketplace, and therefore we project that they would move to the OHP Bridge or Medicaid. [21]

The 2026 enrollment information NovaRest collected did not have income information. To identify the OHP Bridge eligible population we identified the 94% and 87% CSR population, as well as reviewed the 2026 Marketplace Open Enrollment Period Public Use Files[22] to identify the magnitude of APTC non-CSR members that may be eligible.

For 2026 to 2027, we assume 50% of remaining eligible Oregon Marketplace members to leave, which we believe is supported by the high-end estimate of actual leave rates and also reflects the Oregon intention to begin redetermining members for plan year 2027.

For 2027 to 2028, we assume 95% of remaining eligible Oregon Marketplace members to leave, which assumes a very small amount (~ 200) eligible members would remain in the Oregon Marketplace due to unexpected delays in processing all members enrollment, as Oregon has not yet fully implemented the SBM.

For 2029, we expect there will be no further Oregon Marketplace members with incomes between 138% and 200% FPL who are eligible for OHP Bridge.

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[20] Funded under Section 1331 of the ACA.

[21] Via email response from Joel Payton MPA, CA of the Oregon Division of Financial Regulation dated April 15, 2026.

[22] https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2026-marketplace-open-enrollment-period-public-use-files

The claims data NovaRest collected also does not have income information. We reviewed the relative reinsured claim cost for 87% and 94% CSR enrollees compared to Oregon individual ACA market average, and then adjusted the reinsured claims dollars based on the relative claims and number of members we expect to exit the market by year.

Advanced Premium Tax Credit (APTC) and Premium Tax Credit (PTC) Projections

Consistent with the previous 2022 Waiver Extension Request, NovaRest projects APTC as the difference between the gross premium and the net premium for EHBs only. As household income increases, the enrollee's maximum required premium contribution generally increases as well. NovaRest projects household income growth of 4.4% annually and applies the same annual trend to PMPM net premiums.[23] APTCs are then estimated as the difference.

We estimate the PTC as 95% of APTCs based on recent historic ratios published by the IRS,[24,25] and is consistent with the assumption used in the prior extension application.

Oregon Reinsurance Program (ORP) Total Cost Estimation

Consistent with the previous 2022 Waiver Extension Request, the ORP parameters are applied against the trended claims to determine the total ORP cost. In reality the ORP parameters are set annually based on annually refreshed carrier data, however, for projections the ORP parameters do not change. The ORP cost is compared against the projected With 1332 Waiver scenario premiums to determine ORP as a percentage of premium.

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[23] Based on an analysis of FPL increases from 2022 to 2026 from: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references

[24] Health Insurance Premium Tax Credit and Cost-Sharing Reductions. Congressional Research Service. Updated February 19, 2026. https://sgp.fas.org/crs/misc/R44425.pdf

[25] Statistics of Income 2022 IRS Individual Income Tax Returns Complete Report, Figure G. Internal Revenue Service. https://www.irs.gov/pub/irs-pdf/p1304.pdf. The PTC as a % of APTC varied from 97% in 2021 to 88% in 2022. Therefore, we did not change the assumption of 95% from the prior extension application.

Federal Pass-Through Estimation

Consistent with the previous 2022 Waiver Extension Request, the federal pass-through is estimated as the difference between the PTC for the Without 1332 Waiver (Baseline) and With 1332 Waiver scenarios. In the prior extension application NovaRest also considered the reduction in federal government revenue due to a lower Exchange User Fee, however, Oregon is expected to operate a full State-Based Exchange for plan year 2027 and beyond, therefore this adjustment is no longer included.

Oregon currently has a 1332 Waiver. To estimate the Without 1332 Waiver (Baseline), we apply the ORP as a percentage of premium as a premium increase in our modelling, which results in higher premiums, increasing the SLCSP which also results in a higher PTC for the Without 1332 Waiver (Baseline). NovaRest assumed that the ORP percentage of premium impact was the same percentage for all plans due to the single risk pool requirement.[26]

[26] 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.



Appendix B – 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 (ORP).

The goal was to model the individual health insurance market and to project estimated experience for an extended reinsurance program. NovaRest has been helping state insurance regulators meet their regulatory responsibilities since 2002. The 1332 project included two accredited actuaries. The core team members have worked on healthcare actuarial and economic analyses and Section 1332 Waiver projects, including assisting with the prior Oregon extension application which was approved. 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 ACA modeling and project management. In addition, NovaRest has experience working on Section 1332 Waiver and reinsurance projects in other states.

Appendix 6 – Secretary of State audit

Finding 2024-005:	**Department of Consumer and Business Services** **Strengthen review procedures** **Significant Deficiency**
Recommendation:	Department management improve the accounting department's program understanding and strengthen review procedures to ensure transactions are recorded correctly in the accounting records
Status:	Partial corrective action taken. The agency's response is as follows: DCBS will complete the following in relation to the audit recommendations: 1. DCBS will revise the ACFR year-end checklist and closing plan to review the previous year's transactions and any potential impact on the current year's reporting. DCBS will add documentation to the Healthcare Provider Taxes ACFR spreadsheet to ensure there are four quarters of revenue recorded. In addition, DCBS will add documentation on Performance Deposits spreadsheet to ensure the formulas are accurate during creation and review of the documentation. The Accounting manager will oversee this work, and it will be completed by June 2025. 2. DCBS will improve and provide additional training to the Accounting staff on effectively creating and reviewing accounting transactions to ensure accurate and proper recording. In addition, the Accounting manager will meet with transaction reviewers to ensure they fully understand the transactions they are assigned to review. The Accounting manager will oversee this work, and the work will be completed by June 2025. 3. DCBS Accounting staff will meet with the Division of Financial Regulation (DFR) staff responsible for Performance Deposits and Healthcare Provider Taxes to learn more and seek to improve the work done in accounting for these programs. The Accounting manager will oversee this work, and the work will be completed by June 2025.