MEMORANDUM

June 26, 2026

To: Chiqui Flowers, Director of the Oregon Health Insurance Marketplace, Health Policy and Analytics (HPA) Division, Oregon Health Authority
Dr. Sejal Hathi, Director, Oregon Health Authority
Kris Kautz, Deputy Director for Administration, Oregon Health Authority
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From: Caleb Lavan, Senior Manager, CBIZ Optumas

Subject: Oregon Health Insurance Marketplace Report – CY 2027 Administrative Charges
Health Insurance Marketplace Advisory Committee Material

Issue

The Oregon Health Insurance Marketplace (OHIM) is required to review its assessment rates on an annual basis. OHIM needs to determine assessment rates for Marketplace individual medical plans and for stand-alone dental plans for CY 2026. The current assessment rates are:

- $6.85 per member per month (PMPM) for individual medical health plans
- $0.45 PMPM for stand-alone dental plans

ORS 741.105 requires that proposed rates be discussed with the Health Insurance Marketplace Advisory Committee. OAR 945-030-0020 requires a report on the proposed assessment, and a public hearing.

This memo provides information on OHIM expenditures and possible Marketplace enrollment patterns. These generate estimates of the assessment rates that would cover projected operational expenditures for the program. The memo also discusses the costs of the federal technology and the total combined assessment as a percentage of the average premium.

Summary

- We use expenditure assumptions based on estimated monthly expenditures provided by OHIM and the Health Policy and Analytics Business Operations office.
- Preliminary data indicates CY 2027 will have a lower level of enrollment than CY 2026, due to impacts from the end of the Enhanced Premium Tax Credits (EPTC) and continuing affordability issues, the Oregon Health Plan (OHP) Bridge, and insurer withdrawal from the individual market.
- Expenditures are expected to increase with the transition to a state-based marketplace. Payments from insurers will transition away from the federally facilitated marketplace to the state.
- Our analysis suggests that the PMPM rates need to be increased to $35.60 for individual medical health plans and $1.70 for stand-alone dental plans in CY 2026 to cover the operating costs of OHIM.

Assessment rate history

The following table shows the recent history of the Marketplace assessment rates. The rates remained at $5.50 through CY2025, and increased to $6.85 in CY 2026

Marketplace Assessment Rates

	CY 2017 - CY 2019	CY 2020 - CY 2025	CY 2026	CY 2027
Medical PMPM	$6.00	$5.50	$6.85	TBD
Dental PMPM	$0.57	$0.36	$0.45	TBD

The dental assessment rate was set so the ratio of the dental rate to the medical rate equaled the ratio of the average dental premium to the average medical premium. Average dental premiums have not risen as fast as medical premiums, so the dental rate remained unchanged through CY 2025. In CY 2026, it was raised to $0.45.

Current expenditure projections

The following table shows our current expenditure forecast. The figures are based on historical expenditures and expenditure estimates for the next biennium broken down by calendar year provided by staff.

Marketplace Expenditures, Historical and Projected

CY 2022-2025 actuals and CY 2026-2027 forecast

	Marketplace Expenditures	Shared Services / SAEC	Total Expenditures
CY 2022	$6,071,063	$320,887	$6,391,950
CY 2023	$6,563,747	$936,474	$7,500,221
CY 2024	$6,958,386	$1,074,828	$8,033,214
CY 2025	$7,319,331	$1,360,893	$8,680,223
CY 2026	$14,889,794	$1,666,537	$16,556,331
CY 2027 *	$33,924,962	$5,309,994	$39,234,956

SAEC - OHA Shared Assesment and Enterprise-wide Costs

*Expenditure increases in CY 2027 are a result of the transition to a state-based marketplace (SBM).

The table shows actual expenditures for CY 2022 - CY 2025.

Actual expenditures were available through 2025 and projected expenditures from 2026 forward were taken from the expenditure estimates provided by staff.

Marketplace medical plan enrollment forecast

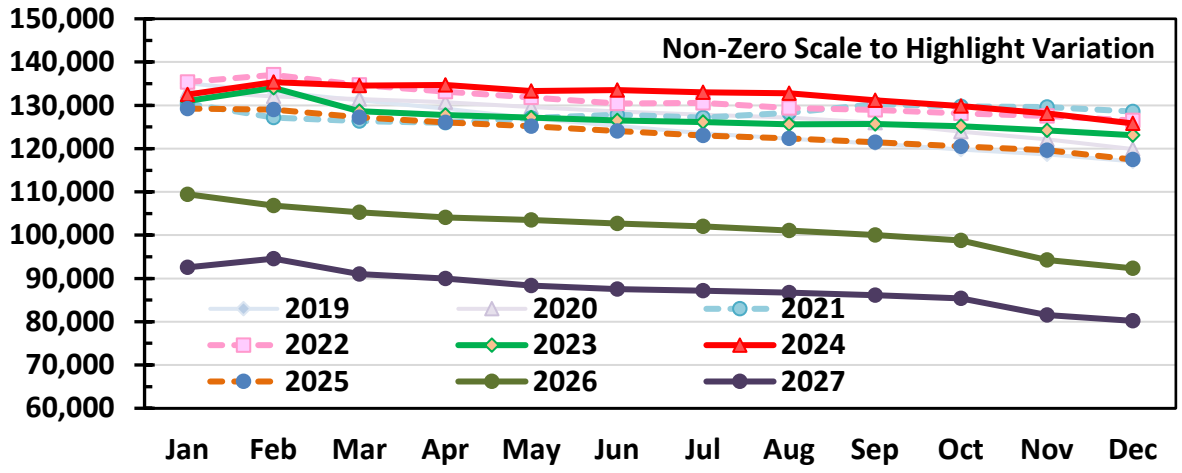
The assessment rate needed to fund the Marketplace's operations is dependent on the forecasted effectuated medical plan enrollment ("medical enrollment").

The basic approach to forecasting the medical enrollment was to create a baseline forecast using the recent history and then adjust that to account for anticipated changes that may impact the medical enrollment.

The first step is to develop the recent history. There can be significant volatility in carriers' reported enrollment. Carriers are allowed to revise enrollment for up to 18 months. Some years the variation is larger than other years. Careful review of trends of missing data from past years showed that the volatility in enrollment numbers was most likely to be present in the preliminary enrollment numbers at the beginning of the year during open enrollment and right after. In years past, this report was completed using only the preliminary enrollment data reported for January and February. As a result, the volatility in the beginning of the year needed to be accounted for in our forecast. This year, the report was contracted for later in the year, allowing the use of enrollment numbers through May of 2026. This allowed time for the January and February enrollment numbers to stabilize. The annual May data does not generally show any significant changes or volatility over time and so we were able to use them without adjustment.

We observed 103,538 enrollees for May 2026. With that value and the stable enrollment numbers from January to April of 2026 as the starting point for the CY 2026, we then applied a seasonal exponential smoothing model to the period from January 2022 to May 2026. This captures the recent trend and seasonal pattern of enrollment. The chart below shows the last several years of medical enrollment. Note the distinct seasonal pattern with the highest enrollment in January and February, during and immediately after open enrollment and then enrollment gradually declining over the year. You will note the 2026 and 2027 numbers are distinctly lower. The drop from 2025 to 2026 was driven in large part by the end of the Enhanced Premium Tax Credit (EPTC), but also the OHP bridge plan. The impact of the end of the EPTC has already occurred, but the transfers to the OHP are ongoing. We will discuss the specifics of the changes next.

Enrollment Model: Effectuated Medical Plan Enrollment, CY 2026 and CY 2027 Forecasted, CY 2026 Actuals, based on May 2026 enrollment reports



Discussion of factors impacting the medical plan enrollment forecast

There are a number of factors that may impact the medical plan enrollment in CY 2027: absence of enhanced premium tax credits, transfers of enrollees to OHP Bridge, and withdrawal of insurers from the individual market. Other factors that could impact medical enrollment but were not directly accounted for in the model include changes to the open enrollment period, end of automatic reenrollment, end of provisional eligibility for advanced premium tax credits, changes in federal legislation and guidance, and the state of the economy. We will discuss the first two factors, which was modeled in the forecast and then we will address the other risks that were not modeled in the forecast.

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

Enhanced premium tax credits were implemented during the pandemic and extended through 2025 to provide greater access to affordable health insurance. These tax credits were used to reduce the insurance premiums that members of Marketplace pay based on income. The average recipient received $800 in additional subsidies according to the US Department of Health and Human Services. This provision of the law sunset at the end of 2025. While most of the impact of the expiration of the EPTC was seen in CY 2026, there may be an additional decrease in Marketplace medical plan enrollments seen in CY 2027, as some members continue to be priced out of the Marketplace due to an increase in premiums.

OHP Bridge

OHP Bridge covers adults with income between 138 and 200 percent of the federal poverty level, providing medical and dental healthcare to members with no premiums, co-payments, or deductibles. Prior to the implementation of the OHP Bridge, the Marketplace covered people with eligibility from 138% FPL and up. A decrease in Marketplace medical plan enrollment is expected as eligible individuals shift their medical plan to coverage under the OHP Bridge.

The impact of OHP Bridge was expected to decrease enrollment over a significant period of time. Approximately 3,150 members are expected to move from the Marketplace to OHP Bridge from June 2026 to December 2026 and an additional 2,850 from January 2027 to July 2027, for a total of 6,000 members over the 12-month timespan

The impact of OHP Bridge was applied to the baseline exponential smoothing forecast model resulting in an estimated average medical enrollment for CY 2027 of 93,182. See the graph below.

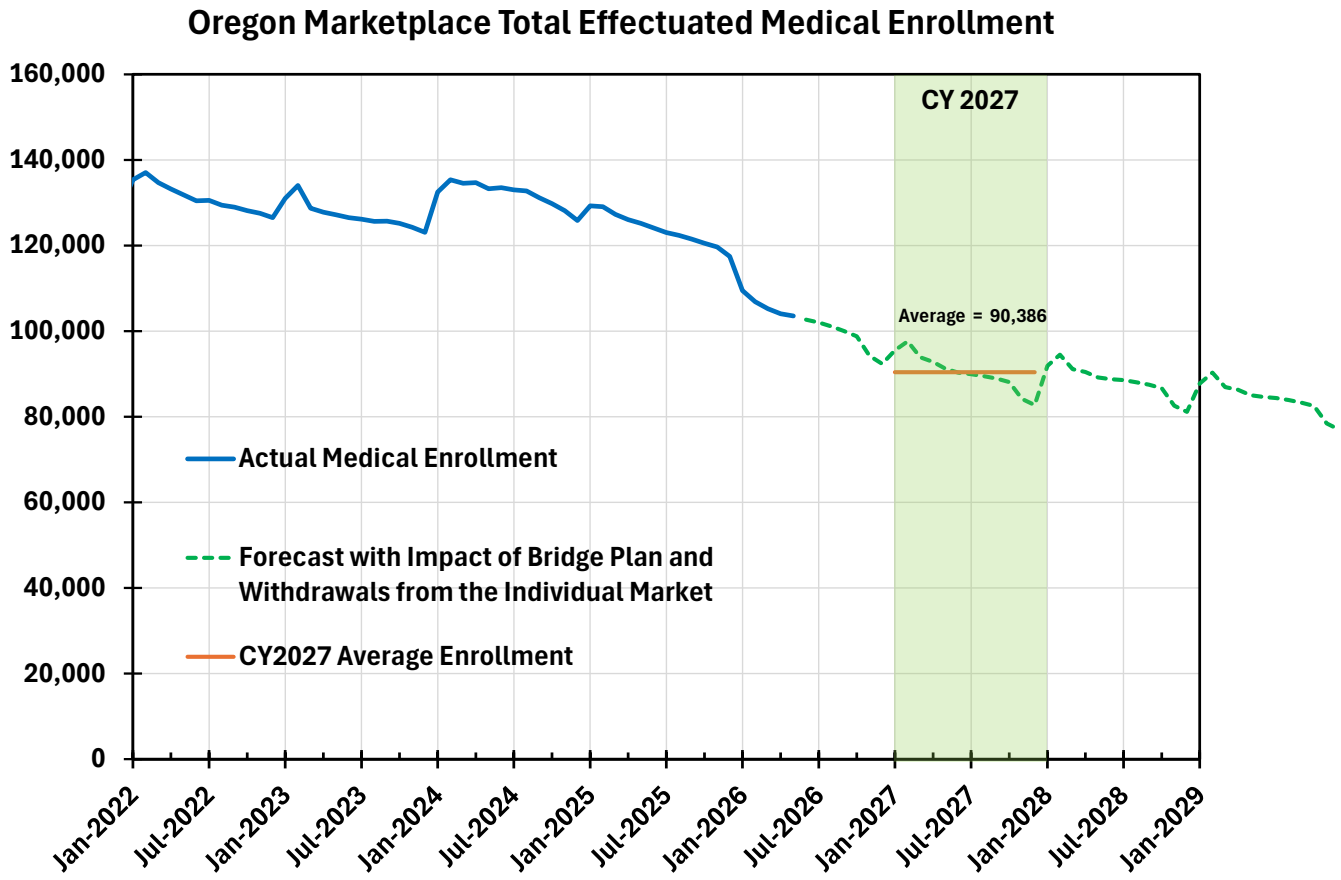
Withdrawal of Insurers from the Individual Market

Two insurers are planning to withdrawal from the marketplace in 2027, Providence and PacificSource. They collectively serve approximately 34% of market. There is some older research that when a participants insurer exits the Healthcare marketplace, it increases the likelihood of the participant disenrolling by a range of 7% to 13%.[1] In this case, 34% will see their insurer exit, corresponding to a range of 2.4% to 4.4% for the total decrease.

[1] Crespin and DeLaire, "As Insurers Exit Affordable Care Act, So Do Consumers", Health Affairs, 38, (2019)

To confirm this estimate, we examined the average disenrollment in 2026 between state-based marketplaces that had no insurer withdrawals and those that did. We used the OEP State Level public use files and examined the disenrollment numbers by state. We also used a list of insurers that had withdrawn by state[2]. Thirteen states with a state-based marketplace had no insurer withdrawals in 2026 and 8 states did. The weighted average disenrollment rate was 19% in states with an insurer withdrawal and 16% in states without a withdrawal, for a difference of 3%. This is consistent with estimate in the previously mentioned paper.

We decreased the enrollment after accounting for the reduction due to the Bridge plan by an additional 3% for our final forecast.



Other Factors Not Included in the Forecast

The open enrollment period causes a significant increase in the number of new enrollees. An increase or decrease to the length of the open enrollment period could increase or decrease the enrollment. In compliance with the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) Marketplace Integrity and Affordability Rule

[2] https://www.healthinsurance.org/faqs/my-health-insurance-company-is-leaving-my-market-what-can-i-do/, Accessed May 21, 2026.

released in 2025, Oregon will be reducing its open enrollment period for plan year 2027 by two weeks and ending it on December 31, 2026.

Federal provisions that proposes additional restrictions on premium tax credits may price individuals out of the Marketplace. Federal legislation such as H.R. 1 implements additional work requirements that may result in individuals losing Medicaid eligibility and enrolling in the Marketplace.

The last factor to consider is the economy and health insurance availability. Fundamentally, the number of people eligible for the Marketplace is driven by how many are in the eligibility bracket (200% FPL and up) and who also lack health insurance. The current job market has been surprisingly steady, and unemployment is relatively low. If that continues, it may lift more people out of Medicaid and onto the Marketplace. It may also lift people into jobs with employer sponsored health insurance and out of the Marketplace. Economic downtown may result in the opposite effects, causing more people to become eligible for Medicaid income requirements, while simultaneously causing people to lose employer sponsored health insurance. The overall impact may be mixed. However, the overall uncertainty and potential volatility is large.

Individual medical plan assessment rates

The following table shows the revenue generated by combinations of individual medical plan enrollment and assessment rates. Under the enrollment model described above, the forecast of the average monthly enrollment for CY 2025 would be 90,386 members. An assessment rate of $35.60 PMPM would generate $38.6 million in revenue. With the same enrollment, a $30.00 PMPM would generate $32.5million. If the average enrollment were 10,000 a month lower than forecast, the $35.60 PMPM would generate $34.3 million; if the enrollment were 10,000 a month higher, the $35.60 PMPM would generate $42.9 million.

CY 2027 Revenue ($millions) by Assessment Rates

Medical Enrollment Forecast	PMPM assessment rates ($dollars)					Equlibrium Rates ($dollars)
	$25.00	$30.00	$35.60	$40.00	$45.00	
Forecast + 15,000	$31.6 mil	$37.9 mil	$45.0 mil	$50.6 mil	$56.9 mil	$30.53
Forecast + 10,000	$30.1 mil	$36.1 mil	$42.9 mil	$48.2 mil	$54.2 mil	$32.05
Forecast + 5,000	$28.6 mil	$34.3 mil	$40.7 mil	$45.8 mil	$51.5 mil	$33.73
Forecast = 90,386	$27.1 mil	$32.5 mil	$38.6 mil	$43.4 mil	$48.8 mil	$35.59
Forecast - 5,000	$25.6 mil	$30.7 mil	$36.5 mil	$41.0 mil	$46.1 mil	$37.68
Forecast - 10,000	$24.1 mil	$28.9 mil	$34.3 mil	$38.6 mil	$43.4 mil	$40.02
Forecast - 15,000	$22.6 mil	$27.1 mil	$32.2 mil	$36.2 mil	$40.7 mil	$42.68

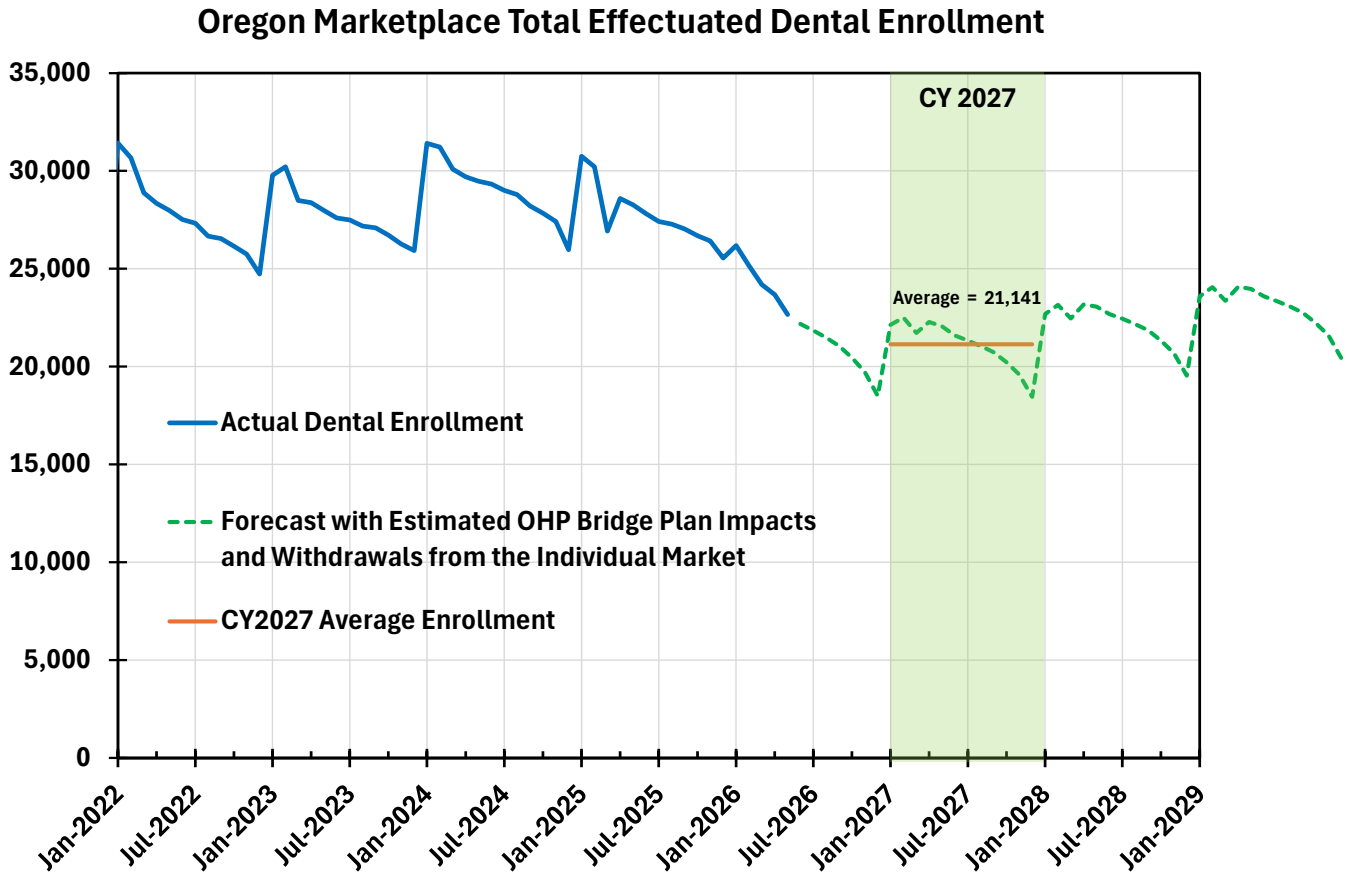
In our financial modeling, we define the "equilibrium rate" as the assessment rate needed to cover one year of expenditures. Using the expenditures described previously, CY 2027 total expenditures are forecasted to be $39,234,956. The dental plan assessment is estimated to raise $431,275 and investment income will generate about $196,980, for a total of $628,255, so the medical plan assessment will need to generate about $ 38.6 million.

The table shows the equilibrium rates for various enrollment forecasts in the right column. If the enrollment forecast is correct, the equilibrium rate for the continuing service level Governor's

Budget expenditures is $35.59 PMPM. If monthly enrollment were 5,000 higher, the equilibrium rate would be $33.73 PMPM.

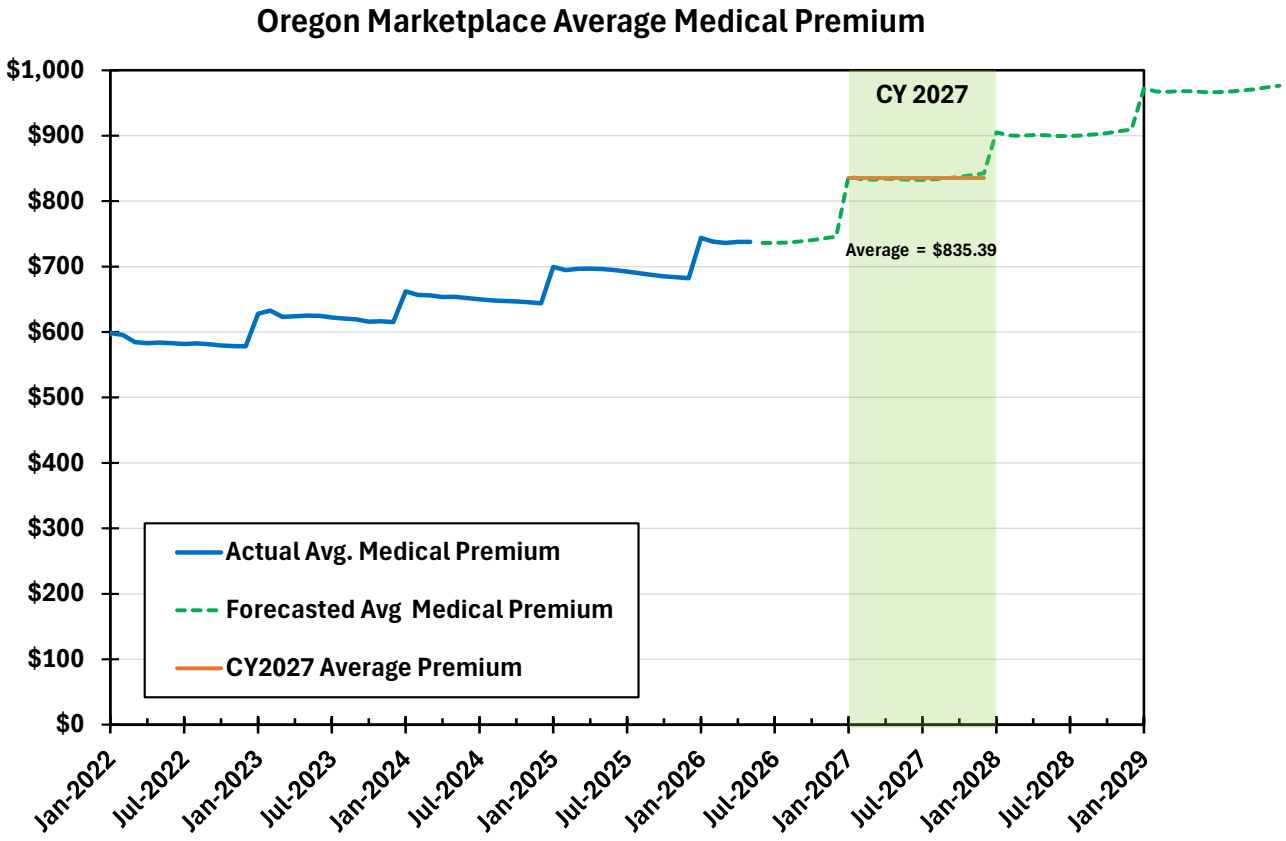
Stand-alone dental plan enrollment and premiums forecast

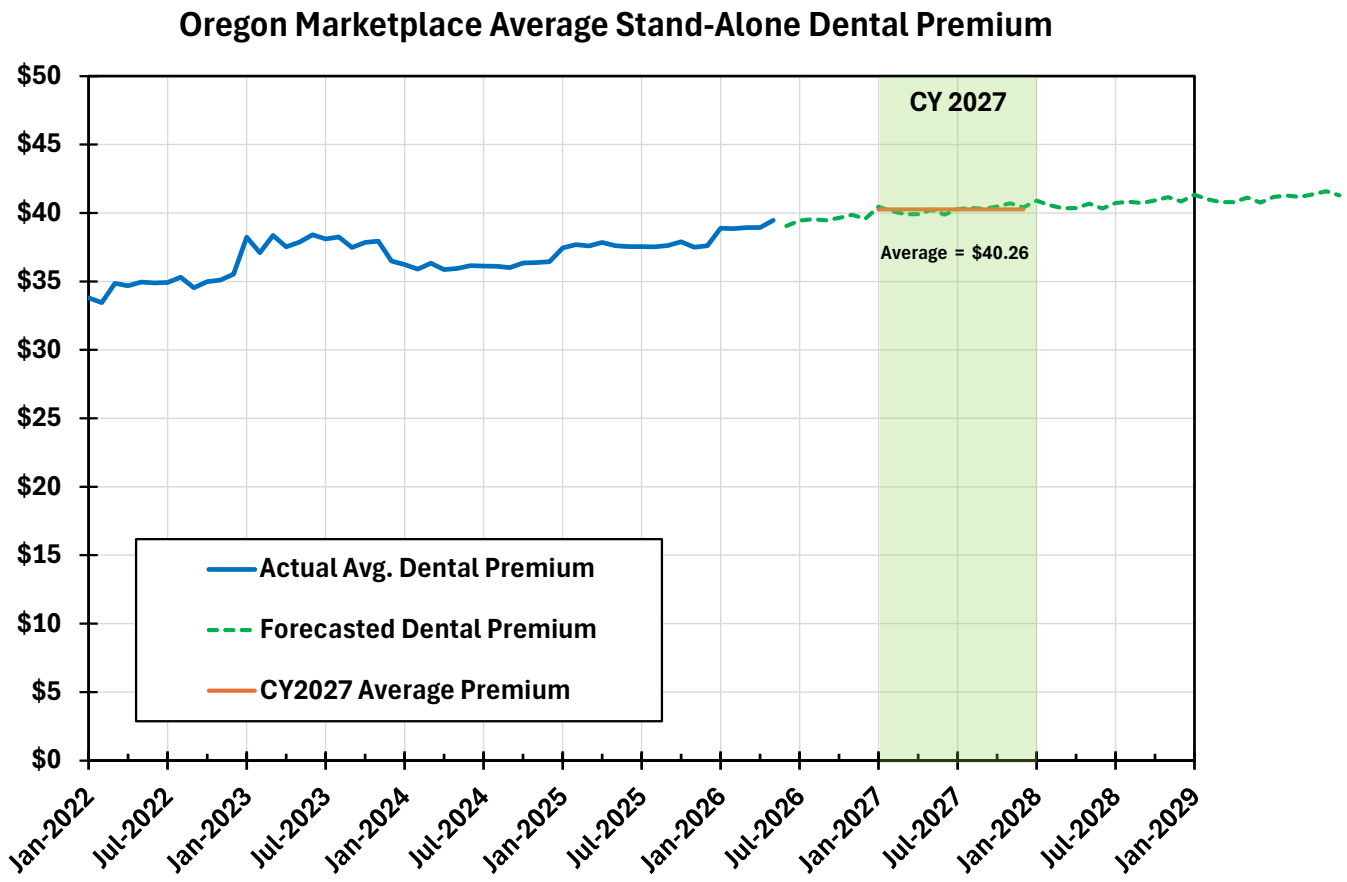
Dental plan enrollment has moved up and down over the last few years. Like the medical enrollment forecast, we first forecast a baseline forecast using an exponential smoothing model. Our forecast for stand-alone dental enrollment decreases the enrollment estimates by the same relative amount as the medical enrollment estimates. There is only one insurer withdrawing from the stand-alone dental market, PacificSource and they have a smaller footprint, we estimate the impact to be a 1% decrease to projected enrollment and that is built into the Dental enrollment forecast.



We also need to forecast medical and dental premiums to ensure that the assessments will not exceed certain limits. Medical premiums have shown significant increases in the last few years. We use the historical value for the average premium by month from January 2022 to May 2026. The discussed premium increases for 2027 are generally higher due to the decrease of enrollment under the end of the Enhanced Premium Tax Credits in 2026. In addition, the 2 insurers withdrawing from the individual market will likely lead to additional increases. We specifically included a 4% increase to premiums for 2027 above the normal forecasted increases to account for these factors. The forecasted average premium in CY 2027 is $835.39. The medical and stand-alone dental premium forecasts are both shown on the next page.

Stand-alone dental premiums have grown slower than medical premiums, but they have increased. We forecast that current trend will continue into CY 2027 and include a 1% increase above the normal forecasted increase. The average premium for a stand-alone dental plan is forecasted to be $40.26.





Enrollment forecast summary

The following table provides a summary by calendar year using the current assessment rates, the proposed enrollment forecast, and the state provided expenditure estimates. The table also includes the forecast average premiums for medical and stand-alone dental policies. CY 2027 and the medical assessment are highlighted with dashed lines.

Medical Plans Summary, with Assessment Rate Assumptions

	2021	2022	2023	2024	2025	2026	2027
Average enrollment	128,217	131,135	127,100	132,045	123,789	101,689	90,386
% change	0.4%	2.3%	-3.1%	3.9%	-6.3%	-17.9%	-11.1%
Total premiums ($ millions)	$886.3	$919.3	$949.1	$1,032.1	$1,027.3	$901.4	$906.1
Avg premium	$576.02	$584.19	$622.29	$651.33	$691.58	$738.71	$835.39
% change	7.8%	1.4%	6.5%	4.7%	6.2%	6.8%	13.1%
Assessment rate	$5.50	$5.50	$5.50	$5.50	$5.50	$6.85	$35.60*
Assessments ($ millions)	$8.5	$8.7	$8.4	$8.7	$8.2	$8.4	$38.6
Rate as % of avg premium	1.0%	0.9%	0.9%	0.8%	0.8%	0.9%	4.3%
Federal tech. charges ($ millions)	$15.5	$20.7	$21.4	$18.6	$12.3	$18.0	$0.0
Fed. as % of avg premium	1.75%	2.25%	2.25%	1.80%	1.20%	2.00%	0.00%

Dental Plans Summary

	2021	2022	2023	2024	2025	2026	2027
Average enrollment	26,367	27,664	27,759	29,039	27,745	22,260	21,141
% change	12.7%	4.9%	0.3%	4.6%	-4.5%	-19.8%	-5.0%
Total premiums ($ millions)	$10.6	$11.5	$12.6	$12.6	$12.5	$10.6	$10.1
Avg premium	$33.42	$34.75	$37.80	$36.15	$37.62	$39.51	$39.86
% change	-7.9%	4.0%	8.8%	-4.4%	4.1%	5.0%	0.9%
Assessment rate	$0.36	$0.36	$0.36	$0.36	$0.36	$0.45	$1.70*
Assessments ($ millions)	$0.114	$0.120	$0.120	$0.125	$0.120	$0.120	$0.431
Rate as % of avg premium	1.1%	1.0%	1.0%	1.0%	1.0%	1.1%	4.3%
Federal tech. charges ($ millions)	$0.185	$0.260	$0.283	$0.227	$0.150	$0.211	$0.000
Fed. as % of avg premium	1.75%	2.25%	2.25%	1.80%	1.20%	2.00%	0.00%

Medical and Dental Combined

	2021	2022	2023	2024	2025	2026	2027
Total premiums ($ millions)	$896.8	$930.8	$961.7	$1,044.7	$1,039.8	$912.0	$916.2
Total assessments ($ millions)	$8.58	$8.77	$8.51	$8.84	$8.29	$8.48	$39.04*
Total fed. Charges ($ millions)	$15.69	$20.94	$21.64	$18.80	$12.48	$18.24	$0.00
Assessment and fed. charges ($ millions)	$24.27	$29.72	$30.15	$27.64	$20.77	$26.72	$39.04
Total % of avg premium	2.7%	3.2%	3.1%	2.6%	2.0%	2.9%	4.3%

***Assessment rate increases in CY 2027 account for expenditure increases as a result of the transition to a state-based marketplace (SBM).**

Marketplace financial outcomes

The following table summarizes the forecast financial outcomes with the current assessment rates. The CY 2022 – CY 2025 figures are actual revenue and expenditures.

The CY 2026 – CY 2027 figures show the forecast if the enrollment and expenditure assumptions are correct. The revenue figures reflect the assessment revenue and investment revenue. The fund balance forecast is forecasted to stay level through CY 2027.

Summary of Financial Outcomes, Current Assessment Rates

	Total Expenditures	Total Revenue	Fund Balance
CY 2022	$6,391,950	$8,131,190	$8,240,013
CY 2023	$7,500,221	$9,395,352	$10,135,144
CY 2024	$8,033,214	$9,753,736	$11,855,666
CY 2025	$8,680,223	$8,788,055	$11,963,498
CY 2026	$16,556,331	$8,835,251	$4,242,418
CY 2027 *	$39,234,956	$39,241,178	$4,248,640

*Expenditure increases in CY 2027 are a result of the transition to a state-based marketplace (SBM).

An assessment rate of $35.60 is recommended as the rate that will keep the fund balance constant through CY 2027. This assessment rate accounts for known impacts to revenue brought in by the Marketplace, such as decreases in enrollment due to continued affordability issues due to EPTC expiration and increasing premiums, transitions to OHP Bridge, and the withdrawal of insurers; and known impacts to expenditures, such as the transition to a state-based marketplace. Due to potential unknown impacts to the Marketplace that may result from pending or additional federal action, an assessment rate was identified that will help maintain the fund balance to support operations if enrollment decreases further.

Text of SB 972 Relating to the health insurance exchange; creating new provisions; amending ORS 741.105 and 741.300; repealing ORS 741.107; and declaring an emergency.

SECTION 1. Section 2 of this 2023 Act is added to and made a part of ORS 741.001 to 741.540.

SECTION 2. The Oregon Health Authority shall procure and administer an information technology platform or service, separate from the federal platform, to provide electronic access to the health insurance exchange in this state on and after November 1, 2026.

SECTION 3. ORS 741.105 is amended to read:

741.105. (1) The Oregon Health Authority shall establish, by rule, an administrative charge. The authority shall impose and collect the charge from all insurers participating in the health insurance exchange or offering a health plan certified by the authority and state programs participating in the health insurance exchange. The Health Insurance Exchange Advisory Committee shall advise the authority in establishing the administrative charge. The charge must be in an amount sufficient to cover the costs of grants to navigators, in-person assisters and application counselors certified under ORS 741.002 and to pay the administrative and operational expenses of the authority in carrying out ORS 741.001 to 741.540. The charge shall be paid in a manner and at intervals prescribed by the authority.

(2)(a) Each insurer's charge shall be based on the number of individuals, excluding individuals enrolled in state programs, who are enrolled in health plans:

(A) Offered by the insurer through the exchange; and

(B) Certified by the authority.

(b) The charge to each state program shall be based on the number of individuals enrolled in state programs offered through the exchange.

(3) The charge imposed under this section may not exceed:

(a) Five percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is at or below 175,000;

(b) Four percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is above 175,000 and at or below 300,000; and

(c) Three percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is above 300,000.

(4)[*(a)*] If charges collected under subsection (1) of this section exceed the amounts needed for the administrative and operational expenses of the authority in administering the health insurance Enrolled Senate Bill 972 (SB 972-INTRO) Page 1 exchange, the excess moneys collected may be held and used by the authority to [*offset future net losses.*]:

(a) Establish or administer the state information technology platform or service that provides electronic access to the health insurance exchange;

(b) Subsidize a state premium assistance program; or

(c) Implement other measures to further advance the intent of the Legislative Assembly described in ORS 741.001.

[*(b) The maximum amount of excess moneys that may be held under this subsection is the total costs and expenses described in subsection (1) of this section anticipated by the authority for a six-month period. Any moneys received that exceed the maximum shall be applied by the authority to reduce the charges imposed by this section.*]

(5) Charges shall be based on annual statements and other reports submitted by insurers and state programs as prescribed by the authority.

(6) In addition to charges imposed under subsection (1) of this section, to the extent permitted by federal law the authority may impose a fee on insurers and state programs participating in the exchange to cover the cost of commissions of insurance producers that are certified by the authority [*or by the United States Department of Health and Human Services*] to facilitate the participation of individuals and employers in the exchange.

(7)(a) The authority shall establish and amend the charges and fees under this section in accordance with ORS 183.310 to 183.410.

(b) If the authority intends to increase an administrative charge or fee, the notice of intended action required by ORS 183.335 shall be sent, if the Legislative Assembly is not in session, to the interim committees of the Legislative Assembly related to health, to the Joint Interim Committee on Ways and Means and to each member of the Legislative Assembly. The Director of the Oregon Health Authority shall appear at the next meetings of the interim committees of the Legislative Assembly related to health and the next meetings of the Joint Interim Committee on Ways and Means that occur after the notice of intended action is sent and fully explain the basis and rationale for the proposed increase in the administrative charges or fees.

(c) If the Legislative Assembly is in session, the authority shall give the notice of intended action to the committees of the Legislative Assembly related to health and to the Joint Committee on Ways and Means and shall appear before the committees to fully explain the basis and rationale for the proposed increase in administrative charges or fees.

(8) All charges and fees collected under this section shall be deposited in the Health Insurance Exchange Fund.

SECTION 4. ORS 741.300 is amended to read: 741.300. As used in ORS 741.001 to 741.540:

(1) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(2) "Essential health benefits" has the meaning given that term in ORS 731.097.

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

(4) "Health care service contractor" has the meaning given that term in ORS 750.005.

(5) "Health insurance" has the meaning given that term in ORS 731.162, excluding disability income insurance.

(6) "Health insurance exchange" or "exchange" means [*the division of the Oregon Health Authority that operates*] an American Health Benefit Exchange as described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(7) "Health plan" means a health benefit plan or dental only benefit plan offered by an insurer.

(8) "Insurer" means an insurer as defined in ORS 731.106 that offers health insurance, a health care service contractor, a prepaid managed care health services organization or a coordinated care organization.

(9) "Insurance producer" has the meaning given that term in ORS 731.104.

(10) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025. Enrolled Senate Bill 972 (SB 972-INTRO) Page 2

(11) "State program" means a program providing medical assistance, as defined in ORS 414.025, and any self-insured health benefit plan or health plan offered to employees by the Public Employees' Benefit Board or the Oregon Educators Benefit Board.

(12) "Qualified health plan" means a health benefit plan certified by the authority in accordance with the requirements, standards and criteria adopted by the authority under ORS 741.310.

(13) "Small Business Health Options Program" or "SHOP" means a health insurance exchange for small employers as described in 42 U.S.C. 18031.

SECTION 5. Section 2 of this 2023 Act is amended to read:

Sec. 2. The Oregon Health Authority shall procure and administer an information technology platform or service, separate from the federal platform, to provide electronic access to the health insurance exchange in this state [on and after November 1, 2026].

SECTION 6. ORS 741.107 is repealed.

SECTION 7. (1) The amendments to section 2 of this 2023 Act by section 5 of this 2023 Act and the amendments to ORS 741.105 and 741.300 by sections 3 and 4 of this 2023 Act become operative on November 1, 2026.

(2) The Oregon Health Authority shall take all steps prior to the operative date specified in subsection (1) of this section that are necessary to carry out the amendments to section 2 of this 2023 Act by section 5 of this 2023 Act and the amendments to ORS 741.105 and 741.300 by sections 3 and 4 of this 2023 Act on the operative date specified in subsection (1) of this section.

SECTION 8. This 2023 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2023 Act takes effect on its passage.

Portions of OAR 945-030-0020 Establishment of Administrative Charge Paid by Insurers

945-030-0020 Establishment of Administrative Charge Paid by Insurers

(1) After consulting with the advisory committee … the Marketplace will annually provide a report on administrative charges to the Director of the Oregon Health Authority.

(2) The report will be posted on the Marketplace's website for public review and comment.

(3) At a minimum, the report will include:

(a) A projection of Marketplace operating expenses, including the Marketplace's share of the authority's shared services expenses and operating expenses borne by the Marketplace and reimbursed by another agency, based on the authority's budgets, assuming for this purpose that the operating expenses in any actual or expected biennial budget are distributed evenly over the biennium;
(b) A projection of Marketplace enrollment for the next calendar year; and
(c) A proposed administrative charge for the next calendar year.

(4) The authority will hold a public hearing on a proposed administrative charge.

(9) By the 30th day of September of every odd year, the department shall:

(a) Determine the maximum amount of funds that the authority may hold under ORS 741.105(3)(b) by calculating:
(A) The Marketplace's fund balance as of the end of the biennium immediately before the date by which the calculation is required to be made minus:
(B) One-fourth of the Marketplace's budgeted operating expenses for the biennium in which the calculation must be made as required by paragraph (9).

(b) Credit each individual carrier participating in the Marketplace an amount equal to the pro-rata share of any positive difference obtained from the calculation described in paragraph (9)(a) of this rule based on the total assessments the carrier reported to the department during the two-year period described in paragraph (9)(a)(A) of this rule plus the pro-rata share of the total assessments reported during the two-year period described in paragraph (9)(a)(A) of this rule by carriers no longer selling qualified health plans through the Marketplace.

(11) Except as provided in paragraph 12 of this rule, the authority shall apply the credit described in paragraph (9)(b) of this rule by reducing each monthly charge assessed during the period described in paragraph (9)(a)(B) by one-eleventh of the credit rounded to the nearest whole dollar beginning the first day of January following the date specified in paragraph (9) of this rule for 11 consecutive months. Any remaining credit rounded to the nearest whole cent shall be credited in the twelfth month.