Senate Bill 1509

Sponsored by Senator BATES (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Provides legislative approval of Oregon Health Authority proposals for coordinated care organizations and Oregon Health Insurance Exchange Corporation business plan for health insurance exchange by repealing provisions of law enacted to require legislative approval. Makes technical corrections.

Establishes criteria for licensing of massage therapy facilities. Specifies operative date of January 2, 2013.

Declares emergency, effective on passage.

1 **A BILL FOR AN ACT**

2 Relating to health; creating new provisions; amending ORS 413.011, 413.033, 414.033, 414.632, 414.635,
3 414.740, 416.540, 687.011, 687.021, 687.071, 687.081, 687.121, 741.381, 743.730, 743.822 and 743.826
4 and section 27, chapter 415, Oregon Laws 2011, and sections 14, 62, 63 and 64, chapter 602,
5 Oregon Laws 2011; and declaring an emergency.

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

7

8 **OREGON INTEGRATED AND COORDINATED HEALTH CARE**
9 **DELIVERY SYSTEM**
10 **(Legislative Approval of Oregon Health Authority Proposals**
11 **Concerning Coordinated Care Organizations)**

12

13 **SECTION 1.** ORS 414.635, as amended by section 9, chapter 602, Oregon Laws 2011, is amended
14 to read:

15 414.635. (1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled
16 in coordinated care organizations that protect against underutilization of services and inappropriate
17 denials of services. In addition to any other consumer rights and responsibilities established by law,
18 each member:

19 (a) Must be encouraged to be an active partner in directing the member's health care and ser-
20 vices and not a passive recipient of care.

21 (b) Must be educated about the coordinated care approach being used in the community and how
22 to navigate the coordinated health care system.

23 (c) Must have access to advocates, including qualified peer wellness specialists where appropri-
24 ate, personal health navigators, and qualified community health workers who are part of the
25 member's care team to provide assistance that is culturally and linguistically appropriate to the
26 member's need to access appropriate services and participate in processes affecting the member's
27 care and services.

28 (d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.
New sections are in **boldfaced** type.

system to use wellness and prevention resources and to make healthy lifestyle choices.

(e) Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs as a whole person.

(2) The authority shall establish and maintain an enrollment process for individuals who are dually eligible for Medicare and Medicaid that promotes continuity of care and that allows the member to disenroll from a coordinated care organization that fails to promptly provide adequate services and:

(a) To enroll in another coordinated care organization of the member's choice; or

(b) If another organization is not available, to receive Medicare-covered services on a fee-for-service basis.

(3) Members and their providers and coordinated care organizations have the right to appeal decisions about care and services through the authority in an expedited manner and in accordance with the contested case procedures in ORS chapter 183.

(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.

(5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.

(6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.

(7) The authority shall maintain the process[*, approved by the Legislative Assembly,*] for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator.

(8) A coordinated care organization may not unreasonably refuse to contract with a licensed health care provider.

(9) The authority shall:

(a) Monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure a consistent response to complaints of violations of consumer rights or protections.

(b) Monitor and report on the statewide health care expenditures and recommend actions appropriate and necessary to contain the growth in health care costs incurred by all sectors of the system.

SECTION 2. Section 14, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 14. (1) Notwithstanding ORS [*414.725 and 414.737*] **414.631 and 414.651**, in any area of the state where a coordinated care organization has not been certified, the Oregon Health Authority shall continue to contract with one or more prepaid managed care health services organizations, as defined in ORS 414.736, that serve the area and that are in compliance with contractual obligations owed to the state or local government.

(2) Prepaid managed care health services organizations contracting with the authority under this section are subject to the applicable requirements for, and are permitted to exercise the rights of, coordinated care organizations under [*sections 4, 6, 8, 10 and 12 of this 2011 Act and*] ORS 414.153, **414.625, 414.635, 414.638, 414.651, 414.655, 414.679,** 414.712, [*414.725,*] 414.728, 414.743,

414.746, 414.760, 416.510 to 416.610, 441.094, 442.464, 655.515, 659.830 and 743.847.

(3) The authority may amend contracts that are in place on [*the effective date of this 2011 Act*] **July 1, 2011,** to allow prepaid managed care health services organizations that meet the criteria [*approved by the Legislative Assembly under section 13 of this 2011 Act*] **adopted by the authority under ORS 414.625** to become coordinated care organizations.

(4) The authority shall continue to renew the contracts of prepaid managed care health services organizations that have a contract with the authority on [*the effective date of this 2011 Act*] **July 1, 2011,** until the earlier of the date the prepaid managed care health services organization becomes a coordinated care organization or July 1, 2014. Contracts with prepaid managed care health services organizations must terminate no later than July 1, 2017.

(5) The authority shall continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a coordinated care organization but no later than July 1, 2013.

(6) Notwithstanding [*sections 4 (1)(g) and 6 (2) of this 2011 Act*] **ORS 414.625 (1)(g) and 414.655 (2)**, the authority shall allow for a period of transition to the full adoption of health information technology by coordinated care organizations and patient centered primary care homes. The authority shall explore options for assisting providers and coordinated care organizations in funding their use of health information technology.

SECTION 3. Section 62, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 62. [*(1)*] The Oregon Health Authority may not implement any [*provisions of this 2011 Act that require*] **provision of chapter 602, Oregon Laws 2011, that requires** federal approval**,** or that [*require*] **requires** federal approval to receive federal financial participation**,** until the authority has received the **federal** approval.

[*(2) Until the authority has received the approval of the Legislative Assembly under section 13 of this 2011 Act, the authority may not:*]

[*(a) Adopt by rule the qualification criteria for a coordinated care organization under section 4 of this 2011 Act or contract with a coordinated care organization;*]

[*(b) Adopt by rule a global budgeting process or establish global budgets for coordinated care organizations; or*]

[*(c) Implement a process for financial reporting by coordinated care organizations or establish financial reporting requirements under ORS 414.725 (1)(c).*]

SECTION 4. Section 63, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 63. The amendments to [*section 8 of this 2011 Act*] **ORS 414.635** by section 9 [*of this 2011 Act*]**, chapter 602, Oregon Laws 2011,** become operative [*January 1, 2014*] **on the effective date of this 2012 Act**.

SECTION 5. Section 64, chapter 602, Oregon Laws 2011, as amended by section 70, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 64. (1) ORS 414.705 is repealed.

(2) Sections 13[*, 14*] and 17 [*of this 2011 Act*]**, chapter 602, Oregon Laws 2011,** are repealed January 2, 2014.

(3) ORS 414.610, 414.630, 414.640, 414.736, 414.738, 414.739 and 414.740 are repealed July 1, 2017.

(4) Section 14, chapter 602, Oregon Laws 2011, as amended by section 2 of this 2012 Act, is repealed July 1, 2017.

(Technical Corrections)

SECTION 6. ORS 414.033 is amended to read:

414.033. The Oregon Health Authority may:

(1) Subject to the allotment system provided for in ORS 291.234 to 291.260, expend such sums as are required to be expended in this state to provide medical assistance. Expenditures for medical assistance include, but are not limited to, expenditures for deductions, cost sharing, enrollment fees, premiums or similar charges imposed with respect to hospital insurance benefits or supplementary health insurance benefits, as established by federal law.

(2) Enter into agreements with, join with or accept grants from, the federal government for cooperative research and demonstration projects for public welfare purposes, including, but not limited to, any project for:

(a) Providing medical assistance to individuals who are dually eligible for Medicare and Medicaid using [*alternative*] **global** payment methodologies or integrated and coordinated health care and services; or

(b) Evaluating service delivery systems.

SECTION 7. ORS 414.632 is amended to read:

414.632. (1) Subject to the Oregon Health Authority obtaining any necessary authorization from the Centers for Medicare and Medicaid Services [*under section 17, chapter 602, Oregon Laws 2011*], coordinated care organizations that meet the criteria adopted under ORS 414.625 are responsible for providing covered Medicare and Medicaid services, other than Medicaid-funded long term care services, to members who are dually eligible for Medicare and Medicaid in addition to medical assistance recipients.

(2) An individual who is dually eligible for Medicare and Medicaid shall be permitted to enroll in and remain enrolled in a:

(a) Program of all-inclusive care for the elderly, as defined in 42 C.F.R. 460.6; and

(b) A Medicare Advantage plan, as defined in 42 C.F.R. 422.2, until the plan is fully integrated into a coordinated care organization.

(3) Except for the enrollment in coordinated care organizations of individuals who are dually eligible for Medicare and Medicaid, the rights and benefits of Medicare beneficiaries under Title XVIII of the Social Security Act shall be preserved.

SECTION 8. ORS 414.740 is amended to read:

414.740. (1) Notwithstanding ORS 414.738 (1), the Oregon Health Authority shall contract under ORS 414.651 with a prepaid group practice health plan that serves at least 200,000 members in this state and that has been issued a certificate of authority by the Department of Consumer and Business Services as a health care service contractor to provide health services as described in ORS [*414.705 (1)(b)*] **414.025 (8)(b)**, (c), (d), (e), (g) and (j). A health plan may also contract with the authority on a prepaid capitated basis to provide the health services described in ORS [*414.705 (1)(k)*] **414.025 (8)(k)** and (L). The authority may accept financial contributions from any public or private entity to help implement and administer the contract. The authority shall seek federal matching funds for any financial contributions received under this section.

(2) In a designated area, in addition to the contract described in subsection (1) of this section, the authority shall contract with prepaid managed care health services organizations to provide health services under ORS 414.631, 414.651 and 414.688 to 414.750.

SECTION 9. ORS 416.540 is amended to read:

416.540. (1) Except as provided in subsection (2) of this section and in ORS 416.590, the Department of Human Services and the Oregon Health Authority shall have a lien upon the amount

1 of any judgment in favor of a recipient or amount payable to the recipient under a settlement or
2 compromise for all assistance received by such recipient from the date of the injury of the recipient
3 to the date of satisfaction of such judgment or payment under such settlement or compromise.
4 (2) The lien does not attach to the amount of any judgment, settlement or compromise to the
5 extent of attorney's fees, costs and expenses incurred by a recipient in securing such judgment,
6 settlement or compromise and to the extent of medical, surgical and hospital expenses incurred by
7 the recipient on account of the personal injuries for which the recipient had a claim.
8 (3) The authority may assign the lien described in subsection (1) of this section to a prepaid
9 managed care health services organization or a coordinated care organization for medical costs in-
10 curred by a recipient:
11 (a) During a period for which the authority paid a capitation or enrollment fee or a payment
12 using [*an alternative*] **a global** payment methodology; and
13 (b) On account of the personal injury for which the recipient had a claim.
14 (4) A prepaid managed care health services organization or a coordinated care organization to
15 which the authority has assigned a lien shall notify the authority no later than 10 days after filing
16 notice of a lien.
17 (5) For the purposes of ORS 416.510 to 416.610, the authority may designate the prepaid managed
18 care health services organization or the coordinated care organization to which a lien is assigned
19 as its designee.
20 (6) If the authority and a prepaid managed care health services organization or a coordinated
21 care organization both have filed a lien, the authority's lien shall be satisfied first.
22 **SECTION 10. ORS 414.631, 414.651 and 414.688 to 414.750 are added to and made a part of**
23 **ORS chapter 414.**
24
25 **OREGON HEALTH INSURANCE EXCHANGE**
26 **(Acknowledgment of Legislative Approval)**
27
28 **SECTION 11.** Section 27, chapter 415, Oregon Laws 2011, is amended to read:
29 **Sec. 27.** [*(1) Section 11 of this 2011 Act becomes operative on the date the Legislative Assembly*
30 *approves the formal business plan submitted by the Oregon Health Insurance Exchange Corporation*
31 *under section 5 (9) of this 2011 Act. This subsection does not prohibit the implementation, on or after*
32 *the effective date of this 2011 Act, of the responsibilities of the Oregon Health Authority or the Oregon*
33 *Health Insurance Exchange Corporation in administering federal grants received for planning, admin-*
34 *istration or information technology for the exchange.*]
35 [*(2)*] The amendments to [*section 11 of this 2011 Act*] **ORS 741.310** by section 12 [*of this 2011*
36 *Act*]**, chapter 415, Oregon Laws 2011,** become operative on [*the later of the date the Legislative*
37 *Assembly approves the formal business plan submitted by the corporation under section 5 (9) of this*
38 *2011 Act or*] January 1, 2016.
39 **SECTION 12.** ORS 413.011 is amended to read:
40 413.011. (1) The duties of the Oregon Health Policy Board are to:
41 (a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS
42 413.032 and all of the authority's departmental divisions[*, including the Oregon Health Insurance*
43 *Exchange described in section 17, chapter 595, Oregon Laws 2009*].
44 (b) Develop and submit a plan to the Legislative Assembly by December 31, 2010, to provide and
45 fund access to affordable, quality health care for all Oregonians by 2015.

(c) Develop a program to provide health insurance premium assistance to all low and moderate income individuals who are legal residents of Oregon.

(d) Establish and continuously refine uniform, statewide health care quality standards for use by all purchasers of health care, third-party payers and health care providers as quality performance benchmarks.

(e) Establish evidence-based clinical standards and practice guidelines that may be used by providers.

(f) Approve and monitor community-centered health initiatives described in ORS 413.032 (1)(i) that are consistent with public health goals, strategies, programs and performance standards adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and shall regularly report to the Legislative Assembly on the accomplishments and needed changes to the initiatives.

(g) Establish cost containment mechanisms to reduce health care costs.

(h) Ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by the expansion in health coverage, health care system transformations, an increasingly diverse population and an aging workforce.

(i) Work with the Oregon congressional delegation to advance the adoption of changes in federal law or policy to promote Oregon's comprehensive health reform plan.

(j) Establish a health benefit package in accordance with ORS 741.340 to be used as the baseline for all health benefit plans offered through the Oregon Health Insurance Exchange.

[*(k) Develop and submit a plan to the Legislative Assembly by December 31, 2010, with recommended policies and procedures for the Oregon Health Insurance Exchange developed in accordance with section 17, chapter 595, Oregon Laws 2009.*]

[*(L) Develop and submit a plan to the Legislative Assembly by December 31, 2010, with recommendations for the development of a publicly owned health benefit plan that operates in the exchange under the same rules and regulations as all health insurance plans offered through the exchange, including fully allocated fixed and variable operating and capital costs.*]

[*(m)*] **(k)** By December 31, 2010, investigate and report to the Legislative Assembly, and annually thereafter, on the feasibility and advisability of future changes to the health insurance market in Oregon, including but not limited to the following:

(A) A requirement for every resident to have health insurance coverage.

(B) A payroll tax as a means to encourage employers to continue providing health insurance to their employees.

[*(C) Expansion of the exchange to include a program of premium assistance and to advance reforms of the insurance market.*]

[*(D)*] **(C)** The implementation of a system of interoperable electronic health records utilized by all health care providers in this state.

[*(n)*] **(L)** Meet cost-containment goals by structuring reimbursement rates to reward comprehensive management of diseases, quality outcomes and the efficient use of resources by promoting cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations.

[*(o)*] **(m)** Oversee the expenditure of moneys from the Health Care Workforce Strategic Fund to support grants to primary care providers and rural health practitioners, to increase the number of primary care educators and to support efforts to create and develop career ladder opportunities.

[*(p)*] **(n)** Work with the Public Health Benefit Purchasers Committee, administrators of the medical assistance program and the Department of Corrections to identify uniform contracting standards for health benefit plans that achieve maximum quality and cost outcomes and align the contracting standards for all state programs to the greatest extent practicable.

(2) The Oregon Health Policy Board is authorized to:

(a) Subject to the approval of the Governor, organize and reorganize the authority as the board considers necessary to properly conduct the work of the authority.

(b) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the board's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

(3) If the board or the authority is unable to perform, in whole or in part, any of the duties described in ORS 413.006 to 413.042, 413.101 and 741.340 without federal approval, the authority is authorized to request, in accordance with ORS 413.072, waivers or other approval necessary to perform those duties. The authority shall implement any portions of those duties not requiring legislative authority or federal approval, to the extent practicable.

(4) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042, 413.101 and 741.340 and by other statutes.

(5) The board shall consult with the Department of Consumer and Business Services in completing the tasks set forth in subsection (1)(j)[*, (k) and (m)(A) and (C)*] **and (k)(A)** of this section.

(Conforming Changes)

SECTION 13. ORS 413.033 is amended to read:

413.033. (1) The Oregon Health Authority is under the supervision and control of a director, who is responsible for the performance of the duties, functions and powers of the authority.

(2) The Governor shall appoint the Director of the Oregon Health Authority, who holds office at the pleasure of the Governor. The appointment of the director shall be subject to confirmation by the Senate in the manner provided by ORS 171.562 and 171.565.

(3)(a) In addition to the procurement authority granted by ORS 179.040 and 279A.050, the director shall have all powers necessary to effectively and expeditiously carry out the duties, functions and powers vested in the authority by ORS 413.032 [*and section 19, chapter 595, Oregon Laws 2009*], and the duties, functions and powers that are shared by or delegated to the authority with respect to the following agencies:

(A) The Oregon Department of Administrative Services;

(B) The Department of Consumer and Business Services; and

(C) The Department of Human Services.

(b) With respect to procurements and contracts that the authority is authorized to conduct or manage, the director may make procurements on behalf of, and supervise the procurement, establishment and administration of contracts entered into by, the departments described in paragraph (a) of this subsection.

(c) Notwithstanding ORS 279B.085, the director may approve a special procurement under paragraph (b) of this subsection that:

(A) Describes the proposed contracting procedure and the goods or services, or the class of goods or services, to be acquired through the special procurement;

(B) Is unlikely to encourage favoritism in the awarding of public contracts or to substantially diminish competition for public contracts; and

(C) Is reasonably expected to result in substantial cost savings to the authority or to the public.

(d) The director shall give public notice of the approval of a proposed special procurement as provided by the authority by rule. The requirements applicable to the Director of the Oregon Department of Administrative Services under ORS 279B.400 apply to the Director of the Oregon Health Authority with respect to special procurements under this subsection.

(e) Notwithstanding ORS 279C.335, the director may exempt a public improvement contract or a class of public improvement contracts that the authority is authorized to conduct or manage from the competitive bidding requirements of ORS 279C.335 (1) if the director makes the findings described in ORS 279C.335 (2). The provisions in ORS 279C.335 (3) to (8) with respect to the Director of the Oregon Department of Administrative Services apply to the Director of the Oregon Health Authority for exemptions granted by the director under this subsection.

(4) The director shall have the power to obtain such other services as the director considers necessary or desirable, including participation in organizations of state insurance supervisory officials and appointment of advisory committees. A member of an advisory committee so appointed shall receive no compensation for services as a member, but, subject to any other applicable law regulating travel and other expenses of state officers, shall receive actual and necessary travel and other expenses incurred in the performance of official duties.

(5) The director may apply for, receive and accept grants, gifts or other payments, including property or services from any governmental or other public or private person and may make arrangement for the use of the receipts, including the undertaking of special studies and other projects relating to the costs of health care, access to health care, public health and health care reform.

SECTION 14. ORS 741.381 is amended to read:

741.381. The activities of insurers working under the direction of the Oregon Health Authority**, the Oregon Health Insurance Exchange Corporation** and the Department of Consumer and Business Services pursuant to ORS 413.011 (1)(j) or participating in the [*Oregon Health Insurance Exchange created under section 17, chapter 595, Oregon Laws 2009*] **health insurance exchange administered under ORS 741.002**[,] do not constitute a conspiracy or restraint of trade or an illegal monopoly, nor are they carried out for the purposes of lessening competition or fixing prices arbitrarily.

SECTION 15. ORS 743.730, as amended by section 49, chapter 500, Oregon Laws 2011, is amended to read:

743.730. For purposes of ORS 743.730 to 743.773:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743.736, 743.760 or 743.761, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer and portability health benefit plans.

(2) "Affiliate" of, or person "affiliated" with, a specified person means any carrier who, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with a specified person. For purposes of this definition, "control" has the meaning given that

term in ORS 732.548.

(3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee in lieu of a preexisting condition exclusion;

(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

(c) During which no premium shall be charged to the enrollee or late enrollee; and

(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under the plan.

(4) "Basic health benefit plan" means a health benefit plan that provides bronze plan coverage and that is approved by the Department of Consumer and Business Services under ORS 743.736.

(5) "Bona fide association" means an association that meets the requirements of 42 U.S.C. 300gg-91 as amended and in effect on March 23, 2010.

(6) "Bronze plan" means a health benefit plan that meets the criteria for a bronze plan prescribed by the director by rule pursuant to ORS 743.822 (2).

(7) "Carrier," except as provided in ORS 743.760, means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

(8) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon Health Insurance Exchange.

(9) "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the enrollee obtains new coverage.

(10) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(11) "Eligible employee" means an employee who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. "Eligible employee" does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the employer for fewer than 90 days are not eligible employees unless the employer so allows.

(12) "Employee" means any individual employed by an employer.

(13) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group, individual or portability health benefit plan who has enrolled for coverage under the

terms of the plan.

(14) "Exchange" means the [*Oregon Health Insurance Exchange established pursuant to section 17, chapter 595, Oregon Laws 2009*] **health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310**.

(15) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

(16) "Financial impairment" means that a carrier is not insolvent and is:

(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(17)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

(A) Group health benefit plans offered to small employers;

(B) Individual health benefit plans; or

(C) Portability health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design or family composition.

(18) "Grandfathered health plan" has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

(19) "Group eligibility waiting period" means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

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

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

(B) Health care service contractor or health maintenance organization subscriber contract; or

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

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

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

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

(C) Medicare supplement insurance policies;

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

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

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

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

(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

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

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

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

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

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

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

(21) "Health statement" means any information that is intended to inform the carrier or insurance producer of the health status of an enrollee or prospective enrollee in a health benefit plan. "Health statement" includes the standard health statement approved by the director under ORS 743.745.

(22) "Individual coverage waiting period" means a period in an individual health benefit plan during which no premiums may be collected and health benefit plan coverage issued is not effective.

(23) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

(24) "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg as amended and in effect on February 17, 2009;

(b) The individual applies for coverage during an open enrollment period;

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

(d) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

(25) "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

(26) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

(27) "Oregon Medical Insurance Pool" means the pool created under ORS 735.610.

(28) "Preexisting condition exclusion" means a health benefit plan provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of ORS 743.730 to 743.773:

(a) Pregnancy does not constitute a preexisting condition except as provided in ORS 743.766;

(b) Genetic information does not constitute a preexisting condition in the absence of a diagnosis of the condition related to such information; and

(c) Except for coverage under an individual grandfathered health plan, a preexisting condition exclusion may not exclude coverage for services, charges or expenses incurred by an individual who is under 19 years of age.

(29) "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

(30) "Rating period" means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

(31) "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

(32) "Silver plan" means an individual or small group health benefit plan that meets the criteria for a silver plan prescribed by the director by rule pursuant to ORS 743.822 (2).

(33)(a) "Small employer" means an employer that employed an average of at least two but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least two eligible employees on the date on which coverage takes effect under a health benefit plan offered by the employer.

(b) Any person that is treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this subsection.

(c) The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

SECTION 16. ORS 743.822 is amended to read:

743.822. (1) [*As a condition of transacting business in the health benefit plan market in this state,*] **In each individual or small group market in which a carrier offers a health benefit plan through the exchange or outside of the exchange,** a carrier [*shall*] **must** offer to residents of this state bronze and silver plans approved by the Department of Consumer and Business Services as meeting the requirements of subsection (2) of this section**.** [*in each individual and small group market in which the carrier offers a health benefit plan through the Oregon Health Insurance Exchange or outside of the exchange.*]

(2) The Director of the Department of Consumer and Business Services shall prescribe by rule the:

(a) Requirements for a bronze plan to ensure that a bronze plan offered in this state is actuarially equivalent to 60 percent of the full actuarial value of benefits included in the essential health benefits package prescribed by the United States Secretary of Health and Human Services under 42 U.S.C. 18022(a).

(b) Requirements for a silver plan to ensure that a silver plan offered in this state is actuarially equivalent to 70 percent of the full actuarial value of benefits included in the essential health benefits package prescribed by the United States Secretary of Health and Human Services under 42 U.S.C. 18022(a).

(c) Form, level of coverage and benefit design for the bronze and silver plans to be used by carriers in the individual and small group market in this state.

SECTION 17. ORS 743.826 is amended to read:

743.826. A carrier may offer a catastrophic plan only through the [*Oregon Health Insurance Exchange*] **exchange** and only to an individual who:

(1) Is under 30 years of age at the beginning of the plan year; or

(2) Is exempt from any state or federal penalties imposed for failing to maintain minimal essential coverage during the plan year.

SECTION 18. ORS 743.822 and 743.826 are added to and made a part of the Insurance Code.

LICENSING OF MASSAGE FACILITIES

SECTION 19. Section 20 of this 2012 Act is added to and made a part of ORS 687.011 to 687.250.

SECTION 20. (1) To be issued a license to operate a massage facility, each applicant shall:

(a) Submit an application to the State Board of Massage Therapists in the form and manner prescribed by the board.

(b) Be 18 years of age or older, if the applicant is a natural person.

(c) Comply with health, safety and infection control requirements adopted by the board and any other state agencies.

(d) Pass an inspection by the board or its authorized representative.

(e) Pay the fees required under ORS 687.071.

(f) If the applicant is an entity other than a natural person:

(A) Be formed and operated in accordance with Oregon law;

(B) Have licensed massage therapists as majority shareholders; and

(C) Make a business registry filing with the Secretary of State.

(2) To be issued a temporary facility permit to operate a massage facility, each applicant must meet all of the requirements in subsection (1)(a) to (c), (e) and (f) of this section. A temporary facility permit authorizes a massage facility to operate for a period not to exceed 30 consecutive calendar days.

(3) Upon receiving an application and payment of fees and upon compliance with any other requirements prescribed by the board by rule, the board may approve the transfer of:

(a) A license to operate a massage facility from one facility to a different facility if the facility receiving the license has been inspected and approved by the board.

(b) The business name of a massage facility to another facility.

(c) A license to operate a massage facility to a new owner of the facility subject to verification that the new owner has made a business registry filing with the Secretary of State.

(4) The owner of a massage facility holding a license or temporary facility permit issued in accordance with this section may advertise the facility's authorized services.

(5) A massage facility that has been issued a license or permit under this section may furnish massage therapy only by individuals who are licensed under ORS 687.011 to 687.250.

SECTION 21. ORS 687.011 is amended to read:

687.011. As used in ORS 687.011 to 687.250, 687.895 and 687.991:

(1) "Board" means the State Board of Massage Therapists.

(2) "Certified class" means a class that is approved by the board and is offered:

(a) By a person or institution licensed as a career school under ORS 345.010 to 345.450;

(b) By a community college and approved by the State Board of Education;

(c) By an accredited college or university; or

(d) In another state and licensed or approved by the appropriate agency in that state.

(3) "Facility" or "massage facility" means an establishment operated on a regular or irregular basis for the purpose of providing massage therapy.

[*(3)*] **(4)** "Fraud or misrepresentation" means knowingly giving misinformation or a false impression through the intentional misstatement of, concealment of or failure to make known a material fact or by other means.

[*(4)*] **(5)** "Manual" means the use of the hands or the feet, or both, or any part of the body in the performance of massage.

[*(5)*] **(6)** "Massage" or "massage therapy" means the use on the human body of pressure, friction, stroking, tapping or kneading, vibration or stretching by manual or mechanical means or gymnastics, with or without appliances such as vibrators, infrared heat, sun lamps and external baths, and with or without lubricants such as salts, powders, liquids or creams for the purpose of, but not limited to, maintaining good health and establishing and maintaining good physical condition.

[*(6)*] **(7)** "Massage therapist" means a person licensed under ORS 687.011 to 687.250, 687.895 and 687.991 to practice massage.

[*(7)*] **(8)** "Practice of massage" means the performance of massage:

(a) For purposes other than sexual contact, as defined in ORS 167.002 (5); and

(b) For compensation.

[*(8)*] **(9)** "Preceptor" means a licensed massage therapist who contracts with an approved school or program of massage to provide direct on-site clinical supervision of a massage student enrolled in a certified class.

[*(9)*] **(10)** "Supervision" means:

(a) The process of overseeing and directing the training of massage students as set forth in rules of the board;

(b) The process of overseeing and directing a licensee being disciplined by the board; or

(c) Voluntary consultation with, and education of, less experienced licensed massage therapists or practitioners in related fields.

[*(10) "Treatment" means the selection, application and practice of massage or massage therapy essential to the effective execution and management of a plan of care.*]

(11) "Unprofessional or dishonorable conduct" means a behavior, practice or condition that is contrary to the ethical standards adopted by the board.

SECTION 22. ORS 687.021 is amended to read:

687.021. (1) [*No person shall*] **A person may not:**

(a) Engage in or purport to be in the practice of massage without a massage therapist license issued by the State Board of Massage Therapists.

(b) Operate a massage facility without a license or temporary facility permit unless the person is an individual licensed massage therapist working out of the individual's own home.

[*(2)*] **(c)** [*It is unlawful to*] Advertise by printed publication or otherwise[*:*]

[*(a)*] the giving of massage [*treatments*] **therapy** in this state by a person not licensed **or holding a temporary facility permit** under ORS 687.011 to 687.250[*, 687.895 and 687.991; or*]**.**

[*(b)*] **(d)** [*The use of*] **Use the word** "massage" in the business name unless the person providing the massage is licensed **or holds a temporary facility permit** under ORS 687.011 to 687.250[*, 687.895 and 687.991*].

[*(3)*] **(2)** The Attorney General, the prosecuting attorney of any county or the board, in its own

name, may maintain an action for an injunction against any person violating this section. An injunction may be issued without proof of actual damage sustained by any person. An injunction does not relieve a person from criminal prosecution for violation of this section or from any other civil, criminal or disciplinary remedy.

SECTION 23. ORS 687.071 is amended to read:

687.071. (1) The State Board of Massage Therapists shall impose fees for the following:

(a) Massage therapist license issuance or renewal.

(b) Examinations and reexaminations.

(c) Inactive status.

(d) Delinquency in renewal of a license.

(e) Temporary practice permit.

(f) Application for massage license examination.

(g) License to operate a massage facility.

(h) Temporary facility permit to operate a massage facility.

(i) Transfers of licenses under section 20 of this 2012 Act.

(2) If the effective period of the initial massage therapist license **or license to operate a massage facility** is to be less than 12 months by reason of the expiration date established by rule of the board, the required license fee shall be prorated to represent one-half of the biennial rate.

(3) The board shall examine or reexamine any applicant for a massage therapist license who pays a fee for each examination and who meets the requirements of ORS 687.051.

(4) The board shall examine or reexamine any applicant for a license to operate a massage facility if the applicant pays a fee for each examination and meets the requirements of section 20 of this 2012 Act.

[*(4)*] **(5)** All moneys received by the board shall be paid into the account created by the board under ORS 182.470 and are appropriated continuously to the board and shall be used only for the administration and enforcement of ORS 687.011 to 687.250, 687.895 and 687.991.

SECTION 24. ORS 687.081 is amended to read:

687.081. (1) The State Board of Massage Therapists may discipline a licensee **or permittee**, deny, suspend, revoke or refuse to renew a license **or temporary facility permit**, issue a reprimand, censure a licensee **or permittee** or place a licensee **or permittee** on probation if the licensee **or permittee**:

(a) Has violated any provision of ORS 687.011 to 687.250, 687.895 and 687.991 or any rule of the board adopted under ORS 687.121.

(b) Has made any false representation or statement to the board in order to induce or prevent action by the board.

(c) Has a physical or mental condition that makes the licensee **or permittee** unable to conduct safely the practice of massage.

(d) Is habitually intemperate in the use of alcoholic beverages or is addicted to the use of habit-forming drugs or controlled substances.

(e) Has misrepresented to any patron any services rendered.

(f) Has been convicted of a crime that bears a demonstrable relationship to the practice of massage.

(g) Fails to meet with any requirement under ORS 687.051.

(h) Violates any provision of ORS 167.002 to 167.027.

(i) Engages in unprofessional or dishonorable conduct.

(j) Has been the subject of disciplinary action as a massage therapist by any other state or territory of the United States or by a foreign country and the board determines that the cause of the disciplinary action would be a violation under ORS 687.011 to 687.250, 687.895 and 687.991 or rules of the board if it occurred in this state.

(2) If the board places a licensee **or permittee** on probation pursuant to subsection (1) of this section, the board may impose and at any time modify the following conditions of probation:

(a) Limitation on the allowed scope of practice.

(b) Referral to the impaired health professional program established under ORS 676.190.

(c) Individual or peer supervision.

(d) Such other conditions as the board may consider necessary for the protection of the public and the rehabilitation of the licensee **or permittee**.

(3) If the board determines that [*a licensee's*] **the** continued practice **of massage by a licensee or permittee** constitutes a serious danger to the public, the board may impose an emergency suspension of the license **or permit** without a hearing. Simultaneous with the order of suspension, the board shall institute proceedings for a hearing as provided under ORS 687.011 to 687.250, 687.895 and 687.991. The suspension shall continue unless and until the licensee **or permittee** obtains injunctive relief from a court of competent jurisdiction or the board determines that the suspension is no longer necessary for the protection of the public.

(4) In addition to the discipline described in subsection (1) of this section, the board may impose a civil penalty as provided under ORS 687.250. Civil penalties under this subsection shall be imposed pursuant to ORS 183.745.

(5) Prior to imposing any of the sanctions authorized under this section, the board shall consider, but is not limited to, the following factors:

(a) The person's past history in observing the provisions of ORS 687.011 to 687.250, 687.895 and 687.991 and the rules adopted pursuant thereto;

(b) The effect of the violation on public safety and welfare;

(c) The degree to which the action subject to sanction violates professional ethics and standards of practice;

(d) The economic and financial condition of the person subject to sanction; and

(e) Any mitigating factors that the board may choose to consider.

(6) In addition to the sanctions authorized by this section, the board may assess against a licensee **or permittee** the costs associated with the disciplinary action taken against the licensee **or permittee**.

(7) The board shall adopt a code of ethical standards for practitioners of massage and shall take appropriate measures to ensure that all applicants and practitioners of massage are aware of those standards.

(8) Upon receipt of a complaint under ORS 687.011 to 687.250, 687.895 and 687.991, the board shall conduct an investigation as described under ORS 676.165.

(9) Information that the board obtains as part of an investigation into licensee**, permittee** or applicant conduct or as part of a contested case proceeding, consent order or stipulated agreement involving licensee**, permittee** or applicant conduct is confidential as provided under ORS 676.175.

SECTION 25. ORS 687.121 is amended to read:

687.121. The State Board of Massage Therapists may adopt rules:

(1) Establishing reasonable standards concerning the sanitary, hygienic and healthful conditions of premises and facilities used by massage therapists.

(2) Relating to the methods and procedures used in the practice of massage.

(3) Governing the examination and investigation of applicants for the licenses **and permits** issued under ORS 687.011 to 687.250, 687.895 and 687.991 and the issuance, renewal, suspension and revocation of such licenses **and permits**.

(4) Setting standards for certifying classes under ORS 687.051.

(5) Requiring that massage therapists supply the board with the accurate, current address or addresses where they practice massage.

(6) Fixing the educational, training and experience requirements for licensing by indorsement or reciprocity.

(7) Establishing requirements for issuance and retention of an inactive license.

(8) Regarding any matter that the board reasonably considers necessary and proper for the administration and enforcement of ORS 687.011 to 687.250, 687.895 and 687.991.

SECTION 26. (1) Section 20 of this 2012 Act and the amendments to ORS 687.011, 687.021, 687.071, 687.081 and 687.121 by sections 21 to 25 of this 2012 Act become operative January 1, 2013.

(2) The State Board of Massage Therapists may take any action prior to January 1, 2013, that is necessary to implement section 20 of this 2012 Act and the amendments to ORS 687.011, 687.021, 687.071, 687.081 and 687.121 by sections 21 to 25 of this 2012 Act on January 1, 2013.

CAPTIONS

SECTION 27. The unit captions used in this 2012 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 2012 Act.

EMERGENCY CLAUSE

SECTION 28. This 2012 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2012 Act takes effect on its passage.