# House Bill 3341

Sponsored by Representative RICHARDSON

## 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.**

Establishes Oregon Health Insurance Exchange to facilitate provision of insurance products to eligible individuals and employers. Specifies composition, duties and functions of exchange. Establishes guaranteed issue and renewal for participating insurance plans. Specifies maximum deductible, coinsurance and out-of-pocket expenses. Requires coverage of specified services.

Requires Director of Department of Consumer and Business Services to certify participating plans. Requires plans to offer Health Benefit Account option. Requires plans to issue standardized Oregon Health Card for payment of health services.

Requires every Oregon resident enrolled in participating plans to file income tax return regardless of income. Provides that return must require information sufficient to assess citizenship, immigration status and residency. Allows taxpayer deduction from taxable income for costs of participating insurance plan.

Establishes web-based Insurance Policy Access Center to provide information about available plans, assistance in choosing plans and information and assistance regarding end-of-life documents.

## A BILL FOR AN ACT

Relating to health insurance; and appropriating money.

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

**SECTION 1. Definitions. As used in sections 1 to 16 of this 2007 Act, the term:**

**(1) "Applicant" means an individual seeking to participate in the Oregon Health Insurance Exchange.**

**(2) "Carrier" means any person or organization subject to the authority of the Director of the Department of Consumer and Business Services that provides health benefit plans or insurance in this state and includes an insurer, a health care service contractor, a fraternal benefit society, a health maintenance organization and a multiple employer welfare arrangement.**

**(3) "Dependent" means:**

**(a) The spouse of the principal insured; or**

**(b) An individual who is related to the principal insured by birth, marriage or adoption and who also meets the definition of a dependent as set forth in the United States Internal Revenue Code (26 U.S.C. 152).**

**(4) "Eligible individual" means an individual who is eligible to participate in the Oregon Health Insurance Exchange by reason of meeting one or more of the following qualifications:**

**(a) The individual is an Oregon resident, meaning that the individual is and continues to be legally domiciled and physically residing on a permanent and full-time basis in a place of permanent habitation in Oregon that remains the person's principal residence and from which the person is absent only for temporary or transitory purposes. A person who is a full-time student attending an institution outside Oregon may maintain his or her Oregon residency.**

**(b) The individual is not a Oregon resident but is employed, at least 20 hours a week on**

**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.

**a regular basis, at a Oregon location by a bona fide employer, and the individual's employer does not offer a group health insurance plan, or the individual is not eligible to participate in any group health insurance plan offered by the individual's employer.**

**(c) The individual, whether a resident or not, is enrolled in, or eligible to enroll in, a participating employer plan.**

**(d) The individual is self-employed in Oregon and, if a nonresident self-employed individual, the individual's principal place of business is in Oregon.**

**(e) The individual is a full-time student attending an institution of higher education located in Oregon.**

**(f) The individual, whether a resident or not, is a dependent of another individual who is an eligible individual.**

**(5) "Employer" means any individual, partnership, association, corporation, business trust or person or group of persons employing one or more individuals and filing payroll tax information on such individual or individuals.**

**(6) "Excepted benefits" means Medicare supplement insurance, specified disease insurance, dental only or vision only insurance, accident only insurance, hospital confinement indemnity coverage, coverage issued as a supplement to liability insurance, long-term care insurance, workers' compensation insurance, loss of income insurance, coverage for medical expenses included as part of any auto, property, casualty or other liability insurance and credit or disability insurance.**

**(7) "Exchange" means the Oregon Health Insurance Exchange created in section 2 of this 2007 Act.**

**(8) "Participating individual" means an individual who has been determined by the Oregon Health Insurance Exchange to be, and continues to remain, an eligible individual for purposes of obtaining coverage under participating insurance plans offered through the Oregon Health Insurance Exchange.**

**(9) "Participating insurance plan" means a health benefit plan, as defined in ORS 743.730, that is offered through the Oregon Health Insurance Exchange.**

**(10) "Plan year" means the 12-month period of time during which the insured is covered under a health benefit plan, as stipulated in the contract governing the plan.**

**(11) "Preexisting condition provision" means a provision in a health benefit plan that limits, denies or excludes benefits for a period of time for an enrollee for expenses or services related to a medical condition that was present before the date the coverage commenced, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. The time period for a preexisting conditions provision begins when an application for insurance is made or when an applicant is in a waiting period for coverage under any plan. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.**

**(12) "Rate" means the premiums or fees charged by a health benefit plan for coverage under the plan.**

**SECTION 2. Oregon Health Insurance Exchange created. (1) The Oregon Health Insurance Exchange is created for the purpose of providing the residents of Oregon, and such other individuals as may be eligible to participate, with greater choice of health insurance products, greater access to health insurance products and greater portability of health insurance.**

**(2) The Oregon Health Insurance Exchange shall operate in accordance with sections 1 to 16 of this 2007 Act and all other laws of this state.**

**(3) All eligible individuals shall be permitted to obtain health insurance benefits through the Oregon Health Insurance Exchange as provided in sections 1 to 16 of this 2007 Act.**

**SECTION 3. Board of directors. (1) The Oregon Health Insurance Exchange shall be governed by a board of directors. The board of directors shall consist of nine members appointed by the Governor. Members of the exchange serve four-year terms.**

**(2) Vacancies on the board of directors shall be filled by appointment by the Governor for the unexpired term of office. Members of the board may be reappointed.**

**(3) The board of directors shall select a chairperson and a vice chairperson. The board of directors shall also select a secretary who need not be a member of the board of directors.**

**(4) The board of directors shall appoint an exchange director, who shall:**

**(a) Be a full-time employee of the exchange;**

**(b) Administer all of the activities and contracts of the exchange;**

**(c) Supervise the staff of the exchange; and**

**(d) Perform such other functions and duties as directed by the board of directors consistent with sections 1 to 16 of this 2007 Act.**

**(5) The exchange director serves at the pleasure of the board of directors.**

**(6) The board of directors shall be authorized to employ staff and other professionals to assist the board in carrying out the provisions of sections 1 to 16 of this 2007 Act.**

**SECTION 4. The first members of the board of directors of the Oregon Health Insurance Exchange shall be appointed to terms of office beginning January 1, 2008. Notwithstanding the term of office specified by section 3 of this 2007 Act, the Governor shall designate three of the initial appointees to serve a term of office ending on December 31, 2009, three of the initial appointees to serve a term of office ending on December 31, 2010, and three of the initial appointees to serve a term of office ending on December 31, 2011.**

**SECTION 5. Duties of exchange. The Oregon Health Insurance Exchange shall:**

**(1) Publicize the existence of the exchange and disseminate information on eligibility requirements and enrollment procedures for the exchange.**

**(2) Establish and administer procedures for enrolling eligible individuals in the exchange, including:**

**(a) Creating a standard application form to collect information necessary to determine the eligibility and previous coverage history of an applicant; and**

**(b) Preparing and distributing certificate of eligibility forms and application forms to insurers and the general public.**

**(3) Establish and administer an Insurance Policy Access Center website where individuals can examine available health insurance options. The website shall be designed to assist an individual in determining the cost of available health insurance options and in determining which health insurance options best suit the individual's needs.**

**(4) Establish and administer procedures for the election of coverage by participating individuals, including preparing and distributing to participating individuals:**

**(a) Descriptions of the coverage, benefits, limitations, copayments and premiums for all participating plans; and**

**(b) Forms and instructions for electing coverage and arranging payment for coverage.**

**(5) Collect and transmit to the applicable participating plans all premium payments or**

**contributions made by or on behalf of participating individuals, including developing mechanisms to:**

**(a) Receive and process automatic payroll deductions for participating individuals enrolled in participating employer plans;**

**(b) Enable participating individuals to pay, in whole or part, for coverage through the exchange by electing to assign to the exchange any federal earned income tax credit payments due the participating individual; and**

**(c) Receive and process any federal or state tax credits or other premium support payments for health insurance that may be established by law.**

**(6) Upon request, issue certificates of previous coverage to all such individuals who cease to be covered by a participating insurance plan.**

**(7) Establish procedures to account for all funds received and disbursed by the exchange, including:**

**(a) Maintaining a separate, segregated management account for the receipt and disbursement of moneys allocated to fund the administration of the exchange; and**

**(b) Maintaining a separate, segregated operations account for the receipt of all premium payments or contributions made by or on behalf of participating individuals and the distribution of premium payments to participating plans.**

**(8) Submit to the Department of Consumer and Business Services, following the end of each plan year, the report of an independent audit of the exchange's accounts for the plan year.**

**SECTION 6. Powers of exchange. The Oregon Health Insurance Exchange may:**

**(1) Contract with vendors to perform one or more of the functions specified in section 5 of this 2007 Act.**

**(2) Contract with private or public social service agencies to administer application, eligibility verification, enrollment and premium payments for specified groups or populations of eligible individuals or participating individuals.**

**(3) Act as the plan administrator for participating employer plans under contract with the employers and to undertake the obligations required of a plan administrator by federal law.**

**(4) Set and collect fees from participating individuals, participating employer plans and participating insurance plans sufficient to fund the cost of administering the exchange.**

**(5) Seek and directly receive grant funding from the United States government, departments or agencies of this state, county or municipal governments or private philanthropic organizations to defray the costs of operating the exchange.**

**(6) Establish and administer rules and procedures governing the operations of the exchange.**

**(7) Establish one or more service centers within this state to facilitate enrollment.**

**(8) Sue and be sued or otherwise take any necessary or proper legal action.**

**SECTION 7. Participation; open enrollment. (1) Any eligible individual may apply to participate in the Oregon Health Insurance Exchange. An employer, a labor union or an educational, professional, civic, trade, church or social organization that has eligible individuals as employees or members may apply on behalf of those individuals. If the exchange determines that an individual is eligible to participate in the exchange, the individual may enroll, or be enrolled by the individual's parent or legal guardian, in a participating insurance plan**

**offered through the exchange during the next open enrollment period or at such other times as are specified in subsection (3) of this section.**

**(2) From November 1 to November 30 of each year, the exchange shall administer an open enrollment period during which any eligible individual may enroll in any health benefit plan offered through the exchange without a waiting period, and may not be denied coverage.**

**(3) An eligible individual may not be denied coverage at a time other than the annual open enrollment period for any of the following reasons, provided the individual applies for coverage within 63 days of the triggering event:**

**(a) The individual loses coverage in an existing health insurance plan due to the death of a spouse, parent or legal guardian;**

**(b) The individual or a covered dependent loses coverage in an existing health insurance plan due to a change in the individual's employment status;**

**(c) The individual or a covered dependent loses coverage in an existing health insurance plan because of a divorce, separation or other change in familial status;**

**(d) The individual loses coverage in an existing health insurance plan because the individual achieves an age at which coverage lapses under that plan;**

**(e) The individual or a covered dependent becomes eligible by becoming a resident of Oregon or because the individual's place of employment has been changed to Oregon;**

**(f) The individual becomes eligible by becoming the spouse or dependent, by reason of marriage, birth, adoption, court order or a change in custody arrangement, of an eligible individual;**

**(g) The individual becomes subject to a court order requiring the individual to provide health insurance coverage to dependents or enters into a new arrangement for the custody of dependents that requires the individual to provide health insurance for those dependents; or**

**(h) The individual loses coverage in a plan offered through the exchange by reason of the plan's terminating participation in the exchange before the end of the plan year.**

**SECTION 8. Plans offered through exchange. (1) A health insurance plan may not be offered through the Oregon Health Insurance Exchange unless the Director of the Department of Consumer and Business Services has first certified to the exchange that:**

**(a) The carrier seeking to offer the plan is authorized to issue health insurance in this state and is in good standing; and**

**(b) The plan meets the requirements of this section, and the plan and the carrier are in compliance with all other applicable health insurance laws of this state.**

**(2) The director may not certify a plan that excludes an eligible individual from coverage.**

**(3) Each certification of a plan is valid for a term of at least one year, but may be automatically renewable from term to term in the absence of notice that:**

**(a) The carrier is no longer authorized to issue health insurance in this state; or**

**(b) The plan or the carrier is no longer a participant in the exchange.**

**(4) The director may withdraw certification of a plan only after notice to the carrier and opportunity for hearing, except that the director may decline to renew the certification of any carrier at the end of a certification term without opportunity for hearing.**

**(5) Each certified plan offered through the exchange shall contain a detailed description of benefits offered, including maximums, limitations, exclusions and other benefit limits.**

**(6) Each certified plan offered through the exchange shall provide, subject to the plan's**

**deductibles and coinsurance or copayment schedule, major medical coverage that includes the following:**

**(a) Hospital benefits;**

**(b) Surgical benefits;**

**(c) In-hospital medical benefits;**

**(d) Ambulatory patient benefits;**

**(e) Prescription drug benefits; and**

**(f) Mental health benefits.**

**(7) Carriers shall offer plans through the exchange at rates that are based on age, geography and family composition and that are determined to be actuarially sound and reasonable by the director.**

**(8) The rates determined for the first plan year for which the plan is offered through the exchange may be adjusted by the carrier for subsequent plan years based on experience and any later modifications to plan benefits, provided that any adjustments in rates are made in advance of the plan year for which the adjustment will apply and are approved by the director.**

**(9) The exchange shall not decline or refuse to offer, or otherwise restrict the offering to any participating individual of, any plan that has obtained, in a timely fashion in advance of the annual open enrollment period, certification by the director in accordance with the provisions of this section.**

**(10) The exchange shall not sponsor any insurance or benefit plan, or contract with any carrier to offer any insurance or benefit plan, as a participating plan that has not first been certified by the director in accordance with the provisions of this section.**

**(11) The exchange shall not impose on any participating plan, or on any carrier or plan seeking to participate in the exchange, any terms or conditions, including any requirements or agreements with respect to rates or benefits, beyond or in addition to those terms and conditions established and imposed by the director in certifying plans under the provisions of this section.**

**(12) The director shall establish and administer regulations and procedures for certifying plans to participate in the exchange in accordance with the provisions of this section.**

**SECTION 9. Deductibles; coinsurance. (1) Participating insurance plans may not have an annual deductible that exceeds $2,000.**

**(2) After payment of the deductible, an insured may be required to contribute up to 20 percent of the cost of the first $5,000 in benefits covered under the plan. In any calendar year, the maximum out-of-pocket cost may not exceed $1,000 for an individual, or $3,000 for a family.**

**(3) An insured may carry over to the following plan year expenses incurred in the final 30 days of the calendar year that are eligible coinsurance costs.**

**(4) All participating insurance plans must provide a maximum lifetime benefit of at least $1 million.**

**SECTION 10. Health Benefit Accounts. (1) Each participating insurance plan shall offer a Health Benefit Account to be funded at the discretion of the insured up to a maximum of $2,000 per covered beneficiary per year. All funds up to the maximum allowed that the insured contributes to the account for the insured or a dependent shall be used to reduce the insured's taxable income under ORS chapter 316.**

**(2) Health Benefit Account funds may be used for bona fide health related expenses such as medical, chiropractic, naturopathic, pre-natal and childbirth care or treatment performed by a licensed practitioner, ambulance, prescription drugs, dental and vision expenses. The insurer may limit costs to be applied toward the deductible to those benefits covered under the insurance plan.**

**(3) Once the Health Benefit Account contains $2,000, amounts exceeding the maximum, including carryover from prior years, may be used to pay long-term care insurance premiums, qualified training or other educational costs for the insured or the insured's family members.**

**SECTION 11. Oregon Health Card. (1) A participating insurance plan shall provide a standardized Oregon Health Card to each insured. The card shall be used to pay for health care services at the point and time of services. The insurer must offer Internet access or a toll-free telephone number for each insured to obtain account balances and identification of services paid for from the account.**

**(2) The Oregon Health Card must utilize electronic benefits transfer technology. Health Benefit Account contributions must be credited to the cardholder's card account.**

**(3) A participating insurer must offer a website for health providers to verify coverage and to charge against the Oregon Health Card account if the provider does not have electronic benefits transfer technology available.**

**(4) Any unused portion of the Health Benefit Account carries over to the following plan year.**

**SECTION 12. Preexisting conditions. (1) Care or treatment for conditions existing within six months prior to the date of application need not be covered by a participating insurance plan but shall be covered by the Oregon Medical Insurance Pool under ORS 735.600 to 735.650.**

**(2) After six consecutive months in which the insured does not receive care or treatment for the condition excluded under subsection (1) of this section, the condition may no longer be excluded from coverage.**

**SECTION 13. Guaranteed renewal. (1) A participating insurance plan may not cancel or refuse to renew an eligible individual's policy, subject to the carrier's rules regarding cancellation for nonpayment of premiums or fraud. A participating insurance plan may not cancel or refuse to renew a policy because of any change in employer or employment status, marital status, health status, age, membership in any organization or other change that does not affect eligibility.**

**(2) An insured eligible individual who is not a resident of this state and who experiences a qualifying event may continue coverage for a period not to exceed 36 months from the date of the qualifying event if the qualifying event is:**

**(a) Loss of eligible individual status because of voluntary or involuntary termination of employment for reasons other than gross misconduct; or**

**(b) Loss of qualified dependent status for any reason.**

**(3) A person electing to continue coverage under subsection (2) of this section must notify the Oregon Health Insurance Exchange of the election within 63 days after the qualifying event.**

**SECTION 14. Dispute resolution. (1) The Director of the Department of Consumer and Business Services shall establish procedures for resolving disputes arising from the operation of the Oregon Health Insurance Exchange, including disputes relating to:**

**(a) The eligibility of an individual to participate in the exchange;**

**(b) The imposition of a coverage surcharge on a participating individual by a participating insurance plan; and**

**(c) The imposition of a preexisting condition provision on a participating individual by a participating plan.**

**(2) If a carrier imposes a preexisting condition provision exclusion or a premium surcharge in connection with enrollment of a participating individual in a participating insurance plan offered by the carrier, and the participating individual disputes the imposition of such an exclusion or surcharge, the participating individual may request that the director issue a determination as to the validity or extent of the exclusion or surcharge. The director shall issue a determination within 30 days after the request is filed with the department.**

**SECTION 15. Participating employer plans. (1) Any employer may apply to the Oregon Health Insurance Exchange to be the sponsor of a participating employer plan. Any employer seeking to be the sponsor of a participating employer plan shall, as a condition of participation in the exchange, enter into a binding agreement with the exchange, which shall include the following conditions:**

**(a) The sponsoring employer designates the exchange director to be the plan administrator for the employer's group health plan, and the exchange director agrees to undertake the obligations required of a plan administrator under federal law.**

**(b) The coverage and benefits offered by participating insurance plans shall constitute the coverage and benefits of the participating employer plan.**

**(2) Any individuals eligible to participate in the exchange by reason of their eligibility for coverage under the participating employer plan, regardless of whether any such individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan, may elect coverage under any insurance plan participating in the exchange, and neither the employer nor the exchange shall limit such individuals' choice of coverage from among all the participating insurance plans.**

**SECTION 16. (1) An insurer may not issue or renew an individual health insurance plan, other than through the Oregon Health Insurance Exchange, after the first day of the plan year following the first regular open enrollment period conducted by the exchange under section 7 of this 2007 Act.**

**(2) An insurer may not issue or renew a group health insurance plan to a small employer with 50 or fewer employees, other than through the exchange, after the first day of the plan year following the first regular open enrollment period conducted by the exchange under section 7 of this 2007 Act.**

**(3) This section does not apply to any health insurance plan that consists solely of one or more excepted benefits.**

**SECTION 17. Mandatory tax returns. (1) All adult Oregon residents participating in insurance plans offered by the Oregon Health Insurance Exchange shall file an annual Oregon income tax return regardless of income.**

**(2) In addition to any information prescribed by the Department of Revenue, the tax return must require information to determine if the filer is a citizen or lawful permanent resident and is a bona fide resident of Oregon.**

**SECTION 18. Tax deduction. Every eligible individual who purchases a participating insurance plan shall be entitled to use the costs of the plan to reduce taxable income under**

**ORS chapter 316.**

**SECTION 19. Advance directives. (1) The Oregon Health Insurance Exchange shall provide incentives for eligible individuals to complete end-of-life documents, such as advance directives, as part of the enrollment process.**

**(2) The Insurance Policy Access Center website established in section 5 of this 2007 Act shall provide information and assistance in completing advance directives, living wills or other end-of-life documents.**

**SECTION 20. The Oregon Health Insurance Exchange Account is established separate and distinct from the General Fund. All moneys received by the Oregon Health Insurance Exchange, other than appropriations from the General Fund, shall be deposited to the account and are continuously appropriated to the exchange to carry out the duties, functions and powers of the exchange.**

**SECTION 21. The section captions used in this 2007 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 2007 Act.**