

# Enrolled Senate Bill 191

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CHAPTER .....

## AN ACT

Relating to long term care insurance; creating new provisions; amending ORS 411.708, 414.025, 743.650, 743.652, 743.653 and 743.655; and declaring an emergency.

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

**SECTION 1.** ORS 743.650 is amended to read:

743.650. (1) ORS 743.650 to 743.656[, 748.603 and 750.055] may be known and cited as the “Long Term Care Insurance Act.”

(2) The purpose of ORS 743.650 to 743.656[, 748.603 and 750.055] is to:

- (a) Promote the public interest in long term care insurance;
  - (b) Promote the availability of long term care insurance policies;
  - (c) Protect applicants for long term care insurance from unfair or deceptive sales or enrollment practices;
  - (d) Establish standards for long term care insurance;
  - (e) Facilitate public understanding and comparison of long term care insurance policies;
  - (f) Facilitate flexibility and innovation in the development of long term care insurance coverage;
- and

(g) [Assure] **Ensure** that Oregon residents who purchase insurance for long term care shall have access to policies providing for a comprehensive range of benefits.

(3) The requirements of ORS 743.650 to 743.656, 748.603 and 750.055 apply to policies and certificates delivered or issued for delivery in this state on or after December 31, 1989. ORS 743.650 to 743.656, 748.603 and 750.055 are not intended to supersede the obligations of entities subject to ORS 743.650 to 743.656, 748.603 and 750.055 to comply with the substance of other applicable insurance laws insofar as such laws do not conflict with ORS 743.650 to 743.656, 748.603 and 750.055, except that laws and rules designed and intended to apply to Medicare supplement insurance policies shall not be applied to long term care insurance. A policy that is not advertised, marketed or offered as long term care insurance or nursing home insurance is not required to meet the requirements of ORS 743.650 to 743.656, 748.603 and 750.055.

**SECTION 2.** ORS 743.652 is amended to read:

743.652. As used in ORS 743.650 to 743.656, [748.603 and 750.055,] unless the context requires otherwise:

- (1) “Applicant” means:

(a) In the case of an individual long term care insurance policy, the person who seeks to contract for benefits; and

(b) In the case of a group long term care insurance policy, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group long term care insurance policy, if the policy has been delivered or issued for delivery in this state.

[(3) "Director" means the Director of the Department of Consumer and Business Services.]

[(4) "Elimination period" means the period at the beginning of a disability during which no benefits are payable.]

[(5) "Functionally necessary" or "functionally impaired" means a need of a person who is not able to perform independently activities of daily living because of a physical or cognitive impairment.]

[(6)] (3) "Group long term care insurance" means a long term care insurance policy that is delivered or issued for delivery in this state and issued to:

(a) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations; [or]

(b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(A) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(B) Has been maintained in good faith for purposes other than obtaining insurance; [or]

(c)(A) An association or a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering [such] **the** policy within this state, the association or associations, or the insurer of the association or associations shall file evidence with the director that the association or associations have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(i) The association or associations hold regular meetings not less than annually to further purposes of the members;

(ii) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(iii) The members have voting privileges and representation on the governing board and committees; and

(B) Sixty days after [such] **the** filing, the association or associations shall be considered to satisfy [such] **the** organizational requirements, unless the director makes a finding that the association or associations do not satisfy those organizational requirements; [and] **or**

(d) A group other than as described in paragraphs (a), (b) and (c) of this subsection, subject to a finding by the director that:

(A) The issuance of the group policy is not contrary to the best interest of the public;

(B) The issuance of the group policy would result in economies of acquisition or administration; and

(C) The benefits are reasonable in relation to the premiums charged.

[(7)] (4) "Long term care insurance" means any insurance **policy or rider** advertised, marketed, offered or designed to provide coverage for not less than 24 **consecutive** months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more [functionally] necessary or medically necessary services, including but not limited to nursing, diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. "Long term care insurance" includes group and individual **annuities and life insurance** policies or riders [whether] **that provide directly or supplement long term care insurance. "Long term care insurance" also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity, and qualified long term care insurance contracts. Long term care insurance may**

be issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; or health maintenance organizations, health care service contractors or any similar organization **to the extent they are otherwise authorized to issue life or health insurance.** “Long term care insurance” [shall] **does not include any insurance policy [which] that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, catastrophic coverage, accident only coverage, specified disease or specified accident coverage or limited benefit health coverage. With regard to life insurance, “long term care insurance” does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and when neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long term care. Notwithstanding any other provision of ORS 743.650 to 743.656, any product advertised, marketed or offered as long term care insurance is subject to ORS 743.650 to 743.656.**

[(8)] (5) “Policy” means any policy, contract, subscriber agreement, rider or indorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital or medical service corporation; prepaid health plan; or health maintenance organization, health care service contractor or any similar organization.

(6) “Qualified long term care insurance” means:

(a) The portion of a life insurance contract that provides long term care insurance coverage by rider or as part of the contract and that satisfies the requirements of section 7702B(b) and (e) of the Internal Revenue Code; or

(b) Individual or group long term care insurance as defined in this section that meets all of the following requirements of section 7702B(b) of the Internal Revenue Code:

(A) The only insurance protection provided under the contract is coverage of qualified long term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(B) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, or would be reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payer. A contract does not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(C) The contract is guaranteed renewable within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code.

(D) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in subparagraph (E) of this paragraph.

(E) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract.

(F) The contract meets the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code.

**SECTION 3.** ORS 743.653 is amended to read:

743.653. [No] Group long term care insurance coverage may **not** be offered to a resident of this state under a group policy issued in another state to a group described in ORS 743.652 [(6)(d)]

(3)(d), unless [the other] **this state or another** state [has] **having** statutory and regulatory long term care insurance requirements substantially similar to those adopted in this state [and the Director of the Department of Consumer and Business Services] has made a determination that such requirements [are substantially similar] **have been met**.

**SECTION 4.** ORS 743.655 is amended to read:

743.655. (1)(a) The Director of the Department of Consumer and Business Services shall adopt rules that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, program for public understanding, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, underwriting at time of application, requirements for replacement, recurrent conditions and definitions of terms. [The director shall adopt rules establishing standards for loss ratios and reserves, provided that a specific reference to long term care insurance is contained in the rules.]

(b) In adopting rules setting standards under this section, the director [shall] **must** give timely notice to, and shall consider recommendations from the Director of Human Services.

(2) [No] **A** long term care insurance policy [shall] **may not**:

(a) Be canceled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care[. This evaluation of the amount of coverage provided shall be based on aggregate days of care covered for lower levels of care, when compared to days of care covered for skilled care];

(d) Exclude coverage for Alzheimer's disease and related dementias;

(e) Be nonrenewed or otherwise terminated for nonpayment of premiums until 31 days overdue and then only after notice of nonpayment is given the policyholder prior to expiration of the 31 days, **except as otherwise provided by rule**; or

(f) Be sold [after December 31, 1989,] to provide less than 24 months' coverage.

(3)(a) [No] **A** long term care insurance policy or certificate other than a policy or certificate issued to a group[, as defined] **described** in ORS 743.652 [(6)(a)] (3)(a), (b) or (c)[, shall] **may not** use a definition of "preexisting condition" [which] **that** is more restrictive than the following: "Preexisting condition" means [the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or] a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(b) [No] **A** long term care insurance policy or certificate other than a policy or certificate thereunder issued to a group [as defined] **described** in ORS 743.652 [(6)(a)] (3)(a), (b) or (c) may **not** exclude coverage for a loss or confinement [which] **that** is the result of a preexisting condition unless [such] **the** loss or confinement begins within six months following the effective date of coverage of an insured person.

(c) The Director **of the Department of Consumer and Business Services** may extend the limitation periods set forth in paragraphs (a) and (b) of this subsection as to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, over the 10 years immediately prior to the date of application, and, on the basis of the answers on the application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed

on the application, need not be covered until the waiting period described in paragraph (b) of this subsection expires. [No] **A** long term care insurance policy or certificate may **not** exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (b) of this subsection[, *unless such waiver or rider has been specifically approved by the director*].

(4) [No] **A** long term care insurance policy [shall] **may not** be delivered or issued for delivery in this state if the policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement; [or]

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care[.]; **or**

(c) **Conditions eligibility for any benefits other than waiver of premium or post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.**

(5)(a) **A long term care insurance policy containing post-confinement, post-acute care or recuperative benefits must clearly label in a separate paragraph of the policy or certificate titled "Limitations or Conditions of Eligibility for Benefits" all such limitations or conditions, including any required number of days of confinement.**

(b) **A long term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days.**

[(5)(a)] (6) Individual long term care insurance [policyholders] **applicants** shall have the right to return the policy **or certificate** within 30 days of its delivery and to have the premium refunded if, after examination of the policy **or certificate**, the [policyholder] **applicant** is not satisfied for any reason. [Individual] Long term care insurance policies [shall] **and certificates must** have a notice prominently printed on the first page [of the policy] or attached thereto stating in substance that the [policyholder shall have] **applicant has** the right to return the policy **or certificate** within 30 days of its delivery and to have the premium refunded if, after examination of the policy[, the policyholder] **or certificate, other than a certificate issued pursuant to a policy issued to a group described in ORS 743.652 (3)(a), the applicant** is not satisfied for any reason. **This subsection also applies to denials of applications. Any refund must be made within 30 days of the return or denial.**

[(b) A person insured under a long term care insurance policy or certificate issued in this state or any other state to a group described in ORS 743.652 (6)(b), (c) or (d) shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason. Long term care insurance policies shall have a notice prominently printed in 10 point type on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.]

[(6)(a)] (7)(a)(A) An outline of coverage shall be delivered to a prospective applicant for long term care insurance at the time of initial solicitation through means [which] **that** prominently direct the attention of the recipient to the document and its purpose.

[(A)] (B) The director [shall] **by rule must** prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

[(B)] (C) In the case of solicitations by an insurance producer, the insurance producer must deliver the outline of coverage prior to the presentation of an application or enrollment form.

[(C)] (D) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(E) **In the case of a policy issued to a group described in ORS 743.652 (3)(a), an outline of coverage is not required to be delivered as long as the information described in paragraph (b) of this subsection is contained in other materials related to the enrollment. Upon request, these other materials must be made available to the director.**

- (b) The outline of coverage [*shall*] **must** include:
- (A) A description of the principal benefits and coverage provided in the policy;
  - (B) A statement of the principal exclusions, reductions and limitations contained in the policy;
  - (C) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;
  - (D) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;
  - (E) A description of the terms under which the policy or certificate may be returned and premium refunded; [*and*]
  - (F) A brief description of the relationship of cost of care and benefits; **and**
  - (G) **A statement that discloses to the policyholder or certificate holder whether the policy is intended to be qualified long term care insurance as defined in ORS 743.652.**
- [(7)] (8) A certificate issued pursuant to a group long term care insurance policy if the policy is delivered or issued for delivery in this state shall include:
- (a) A description of the principal benefits and coverage provided in the policy;
  - (b) A statement of the principal exclusions, reductions and limitations contained in the policy; and
  - (c) A statement that the group master policy determines governing contractual provisions.
- (9) **If an application for a long term care insurance policy or certificate is approved, the insurer must deliver the policy or certificate to the applicant no later than 30 days after the date of approval.**
- (10) **At the time of policy delivery, a policy summary must be delivered for an individual life insurance policy that provides long term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer must deliver the policy summary upon the applicant's request, but regardless of request must make delivery not later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary must also include the provisions required in this subsection. The required provision may be incorporated into a basic illustration or into the life insurance policy summary if required by rule. The following provisions must be included in the summary:**
- (a) **An explanation of how the long term care benefit interacts with other components of the policy, including deductions from death benefits;**
  - (b) **An illustration of the amount of benefits, the length of benefits and the guaranteed lifetime benefits, if any, for each covered person;**
  - (c) **Any exclusions, reductions and limitations on benefits of long term care;**
  - (d) **A statement that any long term care inflation protection option required by rule is not available under the policy; and**
  - (e) **If applicable to the policy type, the following:**
    - (A) **A disclosure of the effects of exercising other rights under the policy;**
    - (B) **A disclosure of guarantees related to long term care costs of insurance charges; and**
    - (C) **Current and projected maximum lifetime benefits.**
- (11) **When a long term care benefit that is funded through a life insurance policy by an acceleration of the death benefit is in benefit payment status, the insurer must provide a monthly report to the policyholder. The report must include:**
- (a) **Any long term care benefits paid out during the month;**
  - (b) **An explanation of any changes in the policy, such as death benefits or cash values, owing to payment of long term care benefits; and**
  - (c) **The amount of long term care benefits existing or remaining.**
- (12) **If a claim under a long term care insurance policy is denied, then not later than the 60th day after the date of a written request by the policyholder or certificate holder, or a representative of either, the insurer must:**
- (a) **Provide a written explanation of the reasons for the denial; and**

**(b) Make available all information directly related to the denial.**

[(8)] **(13)** [No] A policy may **not** be advertised, marketed or offered as long term care or nursing home insurance unless it complies with the provisions of ORS 743.650 to 743.656[, 748.603 and 750.055].

[(9) ORS 743.414 applies to long term care insurance regulated under ORS 743.650 to 743.656, 748.603 and 750.055.]

[(10)] **(14)** Rules adopted pursuant to ORS 743.650 to 743.656[, 748.603 and 750.055] shall be in accordance with the provisions of ORS chapter 183.

**(15) This section is exempt from ORS 743.700.**

**SECTION 5.** Sections 6 and 7 of this 2007 Act are added to and made a part of ORS 743.650 to 743.656.

**SECTION 6.** (1) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long term care insurance policy or certificate or deny an otherwise valid long term care insurance claim upon a showing of a misrepresentation that is material to the acceptance for coverage.

(2) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long term care insurance policy or certificate or deny an otherwise valid long term care insurance claim upon a showing of a misrepresentation that is material to the acceptance for coverage and also pertains to the condition for which benefits are sought.

(3) After a policy or certificate has been in force for two years, the policy or certificate is not contestable upon the ground of misrepresentation alone. The policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(4) A long term care insurance policy or certificate may not be field issued based on medical or health status. A policy or certificate is field issued for the purposes of this subsection if the policy or certificate is issued by an insurance producer or a third party administrator pursuant to underwriting authority granted to the insurance producer or third party administrator by an insurer.

(5) If an insurer has paid benefits under the long term care insurance policy or certificate, the insurer may not recover the benefit payments in the event that the policy or certificate is rescinded.

(6) This section does not apply to the remaining death benefit of a life insurance policy in the event of the death of the insured if the policy accelerates benefits for long term care, but this section otherwise applies to a life insurance policy that accelerates benefits for long term care. In the event of the death of an insured, the remaining death benefits under the life insurance policy are governed by ORS 743.168.

(7) This section is exempt from ORS 743.700.

**SECTION 7.** (1) Except as provided in subsection (2) of this section, a long term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer must provide a contingent benefit upon lapse that is available for a specified period of time following a substantial increase in premium rates.

(2) When a group long term care insurance policy is issued, the offer required in subsection (1) of this section must be made to the group policyholder. However, if the policy is issued as group long term care insurance as described in ORS 743.652 (3)(d), other than to a continuing care retirement community or similar entity, the offering shall be made to each proposed certificate holder.

(3) The Director of the Department of Consumer and Business Services by rule shall specify:

(a) The type or types of nonforfeiture benefits to be offered as part of long term care insurance policies and certificates;

(b) The standards for nonforfeiture benefits; and

(c) The standards governing contingent benefits upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium increase that triggers a contingent benefit upon lapse as described in subsection (1) of this section.

(4) This section is exempt from ORS 743.700.

**SECTION 8.** Section 9 of this 2007 Act is added to and made a part of ORS 744.052 to 744.089.

**SECTION 9.** (1) An individual may not sell, solicit or negotiate long term care insurance unless the individual is licensed as an insurance producer for health or life insurance and satisfies the following training requirements:

(a) The individual must complete a one-time training course of not less than eight hours before selling, soliciting or negotiating long term care insurance; and

(b) The individual must complete ongoing training of not less than four hours in each 24-month period following the one-time training course.

(2) The Director of the Department of Consumer and Business Services may approve as continuing education courses under ORS 744.072 any courses offered to satisfy the training requirements of this section.

(3) The training required by this section must consist of topics related to long term care insurance, long term care services and, if applicable, qualified state long term care insurance partnership programs, including but not limited to:

(a) State and federal rules and requirements and the relationship between qualified state long term care insurance partnership programs and other public and private coverage of long term care services, including Medicaid.

(b) Available long term care services and providers.

(c) Changes or improvements in long term care services or providers.

(d) Alternatives to the purchase of private long term care insurance.

(e) The effect of inflation on benefits and the importance of inflation protection.

(f) Consumer suitability standards and guidelines.

(4) The training required by this section may not include training that is insurer or company product specific or that includes any sales or marketing information, materials or training, other than those required by state or federal law.

(5) An insurer must:

(a) Obtain verification that an insurance producer receives training required by this section before an insurance producer sells, solicits or negotiates the insurer's long term care insurance products.

(b) Maintain records subject to the state's record retention requirements.

(c) Make the verification obtained under paragraph (a) of this subsection available to the director upon request.

(6) An insurer must maintain records with respect to the training of its insurance producers concerning the distribution of its partnership policies that will allow the director to provide assurance to the state Medicaid agency that insurance producers have received training on the topics described in subsection (3)(a) of this section and that insurance producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long term care, including Medicaid, in this state. An insurer must make the records available to the director upon request.

(7) The satisfaction in any state of the training required by this section is considered to satisfy the training required by this section.



**SECTION 9a.** An individual who is licensed on the effective date of this 2007 Act and is subject to the requirements of section 9 (1) of this 2007 Act must, not later than January 31, 2008:

(1) Complete the entire one-time training course required under section 9 (1)(a) of this 2007 Act;

(2) Satisfy qualifications equivalent to the training requirement under section 9 (1)(a) of this 2007 Act as specified by the Director of the Department of Consumer and Business Services by rule; or

(3) Satisfy the training requirement under section 9 (1)(a) of this 2007 Act in part by completing a portion of the one-time training course and for the remainder by satisfying qualifications specified by the director by rule.

**SECTION 10.** ORS 411.708 is amended to read:

411.708. (1) The amount of any assistance paid under ORS 411.706 is a claim against the property or interest in the property belonging to and a part of the estate of any deceased recipient. If the deceased recipient has no estate, the estate of the surviving spouse of the deceased recipient, if any, shall be charged for assistance granted under ORS 411.706 to the deceased recipient or the surviving spouse. There shall be no adjustment or recovery of assistance correctly paid on behalf of any deceased recipient under ORS 411.706 except after the death of the surviving spouse of the deceased recipient, if any, and only at a time when the deceased recipient has no surviving child who is under 21 years of age or who is blind or disabled. Transfers of real or personal property by recipients of assistance without adequate consideration are voidable and may be set aside under ORS 411.620 (2).

(2) Except when there is a surviving spouse, or a surviving child who is under 21 years of age or who is blind or disabled, the amount of any assistance paid under ORS 411.706 is a claim against the estate in any conservatorship proceedings and may be paid pursuant to ORS 125.495.

**(3) A claim under this section shall exclude benefits paid to or on behalf of a beneficiary under a policy of qualified long term care insurance, as defined in ORS 414.025 (2)(t).**

~~[(3)]~~ (4) Nothing in this section authorizes the recovery of the amount of any assistance from the estate or surviving spouse of a recipient to the extent that the need for assistance resulted from a crime committed against the recipient.

**SECTION 11.** ORS 414.025 is amended to read:

414.025. As used in this chapter, unless the context or a specially applicable statutory definition requires otherwise:

(1) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, temporary assistance for needy families granted under ORS 418.035 to 418.125 or federal Supplemental Security Income payments.

(2) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for, but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child under the program for temporary assistance for needy families except for age and regular attendance in school or in a course of professional or technical training.

(e)(A) Is a caretaker relative named in ORS 418.035 (2)(a)(C) who cares for a dependent child who would be a dependent child under the program for temporary assistance for needy families except for age and regular attendance in school or in a course of professional or technical training; or

(B) Is the spouse of such caretaker relative and fulfills the requirements of ORS 418.035 (1).

(f) Is under the age of 21 years, is in a foster family home or licensed child-caring agency or institution under a purchase of care agreement and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Department of Human Services to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative named in ORS 418.035 (2)(a)(C) who cares for a dependent child receiving temporary assistance for needy families or is the spouse of such caretaker relative and fulfills the requirements of ORS 418.035 (1).

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for the mentally retarded; or is under the age of 22 years and is in a psychiatric hospital.

(k) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by the Department of Human Services.

(L) Is a member of a family that received temporary assistance for needy families in at least three of the six months immediately preceding the month in which such family became ineligible for such assistance because of increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of at least six calendar months beginning with the month in which such family became ineligible for assistance because of increased hours of employment or increased earnings.

(m) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(n) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(o) Is an individual or member of a group who, subject to the rules of the department and within available funds, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(p) Is a pregnant woman who would be eligible for temporary assistance for needy families including such aid based on the unemployment of a parent, whether or not the woman is eligible for cash assistance.

(q) Would be eligible for temporary assistance for needy families pursuant to 42 U.S.C. 607 based upon the unemployment of a parent, whether or not the state provides cash assistance.

(r) Except as otherwise provided in this section and to the extent of available funds, is a pregnant woman or child for whom federal financial participation is available under Title XIX of the federal Social Security Act.

(s) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act or is not a full-time student in a post-secondary education program as defined by the Department of Human Services by rule, but whose family income is less than the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department by rule.

**(t) Would be eligible for a category of aid but for the receipt of qualified long term care insurance benefits under a policy or certificate issued on or after January 1, 2008. As used in this paragraph, "qualified long term care insurance" means a policy or certificate of insurance as defined in ORS 743.652 (6).**

(3) "Income" has the meaning given that term in ORS 411.704.

(4) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the Department of Human Services may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(5) "Medical assistance" means so much of the following medical and remedial care and services as may be prescribed by the Department of Human Services according to the standards established pursuant to ORS 414.065, including payments made for services provided under an insurance or

other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

- (a) Inpatient hospital services, other than services in an institution for mental diseases;
- (b) Outpatient hospital services;
- (c) Other laboratory and X-ray services;
- (d) Skilled nursing facility services, other than services in an institution for mental diseases;
- (e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;
- (f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;
- (g) Home health care services;
- (h) Private duty nursing services;
- (i) Clinic services;
- (j) Dental services;
- (k) Physical therapy and related services;
- (L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter 689;
- (m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;
- (n) Other diagnostic, screening, preventive and rehabilitative services;
- (o) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;
- (p) Any other medical care, and any other type of remedial care recognized under state law;
- (q) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental impairments, and such health care, treatment and other measures to correct or ameliorate impairments and chronic conditions discovered thereby;
- (r) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases; and
- (s) Hospice services.

(6) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. "Medical assistance" includes "health services" as defined in ORS 414.705. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(7) "Medically needy" means a person who is a resident of this state and who is considered eligible under federal law for medically needy assistance.

(8) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

**SECTION 12.** The Department of Human Services shall submit to the Centers for Medicare and Medicaid Services a request for approval of a Medicaid state plan amendment that provides for a long term care insurance partnership as defined in section 1917(b)(1)(C)(iii) of the Social Security Act.

**SECTION 13.** The amendments to ORS 411.708 and 414.025 by sections 10 and 11 of this 2007 Act become operative on the day after the date the Department of Human Services receives approval of the Medicaid state plan amendment described in section 12 of this 2007 Act.

**SECTION 14.** The Director of Human Services shall notify Legislative Counsel upon approval of the Medicaid state plan amendment described in section 12 of this 2007 Act.

**SECTION 15.** The Director of Human Services may take any action before the operative date of the amendments to ORS 411.708 and 414.025 by sections 10 and 11 of this 2007 Act that is necessary to enable the director to exercise, on or after the operative date of the amend-

ments to ORS 411.708 and 414.025 by sections 10 and 11 of this 2007 Act, all the duties, functions and powers conferred on the director by this 2007 Act.

**SECTION 16.** The Director of the Department of Consumer and Business Services may take any action before the operative date of sections 6, 7 and 9 of this 2007 Act and the amendments to ORS 743.650, 743.652, 743.653 and 743.655 by sections 1 to 4 of this 2007 Act that is necessary to enable the director to exercise, on or after the operative date of sections 6, 7 and 9 of this 2007 Act and the amendments to ORS 743.650, 743.652, 743.653 and 743.655 by sections 1 to 4 of this 2007 Act, all of the duties, functions and powers conferred on the director by this 2007 Act.

**SECTION 17.** Sections 6, 7 and 9 of this 2007 Act and the amendments to ORS 743.650, 743.652, 743.653 and 743.655 by sections 1 to 4 of this 2007 Act become operative on January 1, 2008.

**SECTION 18.** Sections 6 and 7 of this 2007 Act and the amendments to ORS 743.650, 743.652, 743.653 and 743.655 by sections 1 to 4 of this 2007 Act apply to policies and certificates delivered or issued for delivery on or after January 1, 2008.

**SECTION 19.** This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.

Passed by Senate March 7, 2007

Received by Governor:

Repassed by Senate June 8, 2007

.....M.,....., 2007

Approved:

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Secretary of Senate

.....M.,....., 2007

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President of Senate

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Governor

Passed by House June 5, 2007

Filed in Office of Secretary of State:

.....M.,....., 2007

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Speaker of House

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Secretary of State