# B-Engrossed
# Senate Bill 101

Ordered by the Senate June 21
Including Senate Amendments dated April 12 and June 21

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Governor John A. Kitzhaber for Oregon Health Authority)

## 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.

Authorizes payment for dental services under Family Health Insurance Assistance Program and under private health option of Health Care for All Oregon Children program. Specifies requirements for dental plan to qualify for premium assistance under Family Health Insurance Assistance Program.

**Requires Oregon Health Authority to obtain authority to implement, on September 1, 2011, new Medicaid fee schedule. Requires negotiating of new contract between hospitals and fully capitated health plans in anticipation of new schedule. Sets rates of reimbursement for hospitals and fully capitated health plans that do not have contract. Eliminates sunset on provision regulating setting of such rates.**

Declares emergency, effective on passage.

## A BILL FOR AN ACT

Relating to health care; creating new provisions; amending ORS 414.025, 414.743, 414.826, 414.841, 414.842, 414.844 and 414.851; repealing sections 6, 7 and 8, chapter 886, Oregon Laws 2009; and declaring an emergency.

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

**SECTION 1.** ORS 414.826 is amended to read:

414.826. (1) As used in this section:

(a) "Child" means a person under 19 years of age who is lawfully present in this state.

**(b) "Dental plan" has the meaning given that term in ORS 414.841.**

[*(b)*] **(c)** "Health benefit plan" has the meaning given that term in ORS 414.841.

(2) The Office of Private Health Partnerships shall administer a private health option to expand access to private health insurance for Oregon's children.

(3) The office shall adopt by rule criteria for health benefit plans to qualify for premium assistance under the private health option. The criteria may include, but are not limited to, the following:

(a) The health benefit plan meets or exceeds the requirements for a basic benchmark health benefit plan under ORS 414.856.

(b) The health benefit plan offers a benefit package comparable to the health services provided to children receiving medical assistance, including mental health, vision and dental services, and without any exclusion of or delay of coverage for preexisting conditions.

(c) The health benefit plan imposes copayments or other cost sharing that is based upon a family's ability to pay.

(d) Expenditures for the health benefit plan qualify for federal financial participation.

**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.

**(4) To qualify for premium assistance under the private health option:**

**(a) A dental plan must provide coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions.**

**(b) Expenditures for the dental plan must qualify for federal financial participation.**

[*(4)*] **(5)** The amount of premium assistance provided under this section shall be:

(a) Equal to the full cost of the [*premium*] **premiums for a health benefit plan and a dental plan** for children whose family income is at or below 200 percent of the federal poverty guidelines and who have access to employer sponsored health insurance; and

(b) Based on a sliding scale under criteria established by the office by rule for children whose family income is above 200 percent but at or below 300 percent of the federal poverty guidelines, regardless of whether the child has access to coverage under an employer sponsored health benefit plan **or dental plan**.

[*(5)*] **(6)** A child whose family income is more than 300 percent of the federal poverty guidelines shall be offered the opportunity to purchase a health benefit plan **or dental plan** through the private health option but may not receive premium assistance.

**SECTION 2.** ORS 414.841 is amended to read:

414.841. For purposes of ORS 414.841 to 414.864:

(1) "Carrier" has the meaning given that term in ORS 735.700.

**(2) "Dental plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement only for the expenses of dental care.**

[*(2)*] **(3)** "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) **Is** either**:**

**(A) For health benefit plan coverage other than dental plans, a person who** has been without health benefit plan coverage for a period of time established by the Office of Private Health Partnerships[,] or meets exception criteria established by the office; **or**

**(B) For dental plan coverage, an individual under 19 years of age who is uninsured or underinsured with respect to dental plan coverage;**

(d) Except as otherwise provided by the office, has family income [*less than*] **at or below** 200 percent of the federal poverty level; **and**

[*(e) Has investments and savings less than the limit established by the office; and*]

[*(f)*] **(e)** Meets other eligibility criteria established by the office.

[*(3)(a)*] **(4)(a)** "Family" means:

(A) A single individual;

(B) An adult and the adult's spouse;

(C) An adult and the adult's spouse, all unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult or the adult's spouse, and all dependent children of a dependent child; or

(D) An adult and the adult's unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult, and all dependent children of a dependent child.

(b) A family includes a dependent elderly relative or a dependent adult child with a disability

who meets the criteria established by the office and who lives in the home of the adult described in paragraph (a) of this subsection.

[*(4)(a)*] **(5)(a)** "Health benefit plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement for hospital, medical and surgical expenses. "Health benefit plan" includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital indemnity only, [*dental only,*] vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.

[*(5)*] **(6)** "Income" means gross income in cash or kind available to the applicant or the applicant's family. Income does not include earned income of the applicant's children or income earned by a spouse if there is a legal separation.

[*(6) "Investment 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 office may establish that are available to the applicant or the applicant's family to contribute toward meeting the needs of an applicant or eligible individual.*]

(7) "Medicaid" means medical assistance provided under 42 U.S.C. section 1396a (section 1902 of the Social Security Act).

(8) "Resident" means an individual who meets the residency requirements established by rule by the office.

(9) "Subsidy" means payment or reimbursement to an eligible individual toward the purchase of a health benefit plan, and may include a net billing arrangement with carriers or a prospective or retrospective payment for health benefit plan premiums and eligible copayments or deductible expenses directly related to the eligible individual.

(10) "Third-party administrator" means any insurance company or other entity licensed under the Insurance Code to administer health [*insurance*] benefit [*programs*] **plans**.

**SECTION 3.** ORS 414.844 is amended to read:

414.844. (1) To enroll in the Family Health Insurance Assistance Program established in ORS 414.841 to 414.864, an applicant shall submit a written application to the Office of Private Health Partnerships or to the third-party administrator contracted by the office to administer the program pursuant to ORS 414.842 in the form and manner prescribed by the office. Except as provided in ORS 414.848, if the applicant qualifies as an eligible individual, the applicant shall either be enrolled in the program or placed on a waiting list for enrollment.

(2) After an eligible individual has enrolled in the program, the individual shall remain eligible for enrollment for the period of time established by the office.

(3) After an eligible individual has enrolled in the program, the office or third-party administrator shall issue subsidies in an amount determined pursuant to ORS 414.846 to either the eligible

individual or to the carrier designated by the eligible individual, subject to the following restrictions:

(a) Subsidies may not be issued to an eligible individual unless all eligible children, if any, in the eligible individual's family are covered under a health benefit plan or Medicaid.

(b) Subsidies may not be used to subsidize premiums on a health benefit plan whose premiums are wholly paid by the eligible individual's employer without contribution from the employee.

(c) Such other restrictions as the office may adopt.

(4) The office may issue subsidies to an eligible individual in advance of a purchase of a health benefit plan.

(5) To remain eligible for a subsidy, an eligible individual must enroll in a group health benefit plan if a plan is available to the eligible individual through the individual's employment and the employer makes a monetary contribution toward the cost of the plan, unless the office implements specific cost or benefit structure criteria that make enrollment in an individual health insurance plan more advantageous for the eligible individual.

[*(6) Notwithstanding ORS 414.841 (4)(b), if an eligible individual is enrolled in a group health benefit plan available to the eligible individual through the individual's employment and the employer requires enrollment in both a health benefit plan and a dental plan, the individual is eligible for a subsidy for both the health benefit plan and the dental plan.*]

**SECTION 4.** ORS 414.851 is amended to read:

414.851. **(1)** The Office of Private Health Partnerships may, based on the recommendation of the Administrator of the Office for Oregon Health Policy and Research, establish minimum benefit requirements for individual health benefit plans subject to subsidy pursuant to the Family Health Insurance Assistance Program, including but not limited to the type of services covered and the amount of cost sharing to be allowed.

**(2) To qualify for premium assistance under the Family Health Insurance Assistance Program:**

**(a) A dental plan must provide coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions.**

**(b) Expenditures for the dental plan must qualify for federal financial participation.**

**SECTION 5.** ORS 414.025, as amended by section 1, chapter 73, Oregon Laws 2010, 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, aid granted under ORS 412.001 to 412.069 and 418.647 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 a category of aid 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 as defined in ORS 412.001 except for age and regular attendance in school or in a course of professional or technical training.

(e)(A) Is a caretaker relative, as defined in ORS 412.001, who cares for a child who would be a dependent child except for age and regular attendance in school or in a course of professional or technical training; or

(B) Is the spouse of the caretaker relative.

(f) Is under the age of 21 years and:

(A) Is in a foster family home or licensed child-caring agency or institution and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part; or

(B) Is 18 years of age or older, is one for whom federal financial participation is available under Title XIX or XXI of the federal Social Security Act and who met the criteria in subparagraph (A) of this paragraph immediately prior to the person's 18th birthday.

(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 as defined in ORS 412.001 who cares for a dependent child receiving aid granted under ORS 412.001 to 412.069 and 418.647 or is the spouse of the caretaker relative.

(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 persons with mental retardation.

(k) Is under the age of 22 years and is in a psychiatric hospital.

(L) 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.

(m) Is a member of a family that received aid in the preceding month under ORS 412.006 or 412.014 and became ineligible for aid due to 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 due to increased hours of employment or increased earnings.

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

(o) 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.

(p) Is an individual or member of a group who, subject to the rules of the department, 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.

(q) Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to 412.069 and 418.647, whether or not the woman is eligible for cash assistance.

(r) Except as otherwise provided in this section, is a pregnant woman or child for whom federal financial participation is available under Title XIX or XXI 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*] **at or below** 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).

(u) Is eligible for the Health Care for All Oregon Children program established in ORS 414.231.

(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 Oregon Health Authority according to the standards established pursuant to ORS [*413.032*] **414.065**, including **premium assistance and** 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 6.** ORS 414.842 is amended to read:

414.842. (1) There is established the Family Health Insurance Assistance Program in the Office of Private Health Partnerships. The purpose of the program is to remove economic barriers to health insurance coverage for residents of the State of Oregon with family income [*less than*] **at or below** 200 percent of the federal poverty level[*, and investment and savings less than the limit established by the office,*] while encouraging individual responsibility, promoting health benefit plan coverage of children, building on the private sector health benefit plan system and encouraging employer and employee participation in employer-sponsored health benefit plan coverage.

(2) The Office of Private Health Partnerships shall be responsible for the implementation and operation of the Family Health Insurance Assistance Program. The Administrator of the Office for Oregon Health Policy and Research, in consultation with the Oregon Health Policy Board, shall make recommendations to the Office of Private Health Partnerships regarding program policy, including but not limited to eligibility requirements, assistance levels, benefit criteria and carrier participation.

(3) The Office of Private Health Partnerships may contract with one or more third-party administrators to administer one or more components of the Family Health Insurance Assistance Program. Duties of a third-party administrator may include but are not limited to:

(a) Eligibility determination;

(b) Data collection;

(c) Assistance payments;

(d) Financial tracking and reporting; and

(e) Such other services as the office may deem necessary for the administration of the program.

(4) If the office decides to enter into a contract with a third-party administrator pursuant to subsection (3) of this section, the office shall engage in competitive bidding. The office shall evaluate bids according to criteria established by the office, including but not limited to:

(a) The bidder's proven ability to administer a program of the size of the Family Health Insurance Assistance Program;

(b) The efficiency of the bidder's payment procedures;

(c) The estimate provided of the total charges necessary to administer the program; and

(d) The bidder's ability to operate the program in a cost-effective manner.

**SECTION 7. (1) As used in this section, "fully capitated health plan" has the meaning given that term in ORS 414.736.**

**(2) The Oregon Health Authority shall proceed with all due diligence and speed to obtain the appropriate authorization to implement on September 1, 2011, a new Medicaid fee schedule that is based upon the legislatively approved budget.**

**(3) Before September 1, 2011, a hospital and a fully capitated health plan shall maintain their existing contract for the provision of inpatient or outpatient hospital services under ORS 414.705 to 414.750, unless the hospital and the plan mutually agree upon a change to the**

**contract. During this time, the hospital and the plan shall work in good faith to negotiate a new contract in anticipation of the implementation of a new Medicaid fee schedule on September 1, 2011.**

**(4) On or after September 1, 2011, a fully capitated health plan that does not have a contract with a hospital that provides 10 percent or more of hospital admissions and outpatient hospital services to enrollees of the plan may, when mutually agreed to by the plan and the hospital, engage in binding arbitration. The binding arbitration must be completed no later than December 1, 2011. The hospital and the plan shall agree upon the arbitrator.**

**(5) The authority shall report to the Legislative Assembly no later than February 1, 2012, the results of the contracting carried out under this section.**

**SECTION 8.** ORS 414.743 is amended to read:

414.743. (1) **Except as provided in subsection (2) of this section,** a fully capitated health plan that does not have a contract with a hospital to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must, using [*a*] Medicare payment methodology, reimburse the noncontracting hospital for services provided to an enrollee of the plan at a rate no less than a percentage of the Medicare reimbursement rate for those services. The percentage of the Medicare reimbursement rate that is used to determine the reimbursement rate under this subsection is equal to [*two*] **four** percentage points less than the percentage of Medicare cost used by the authority in calculating the base hospital capitation payment to the plan, excluding any supplemental payments.

**(2)(a) If a fully capitated health plan does not have a contract with a hospital, and the hospital provides less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement rate that is used to determine the reimbursement rate under subsection (1) of this section is equal to two percentage points less than the percentage of Medicare cost used by the Oregon Health Authority in calculating the base hospital capitation payment to the plan, excluding any supplemental payments.**

**(b) This subsection is not intended to discourage a fully capitated health plan and a hospital from entering into a contract and is intended to apply to hospitals that provide primarily, but not exclusively, specialty and emergency care to enrollees of the plan.**

[*(2)*] **(3)** A hospital that does not have a contract with a fully capitated health plan to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must accept as payment in full for hospital services the rates described in [*subsection (1)*] **subsections (1) and (2)** of this section.

[*(3)*] **(4)** This section does not apply to type A and type B hospitals, as described in ORS 442.470, and rural critical access hospitals, as defined in ORS 315.613.

[*(4)*] **(5)** The Oregon Health Authority shall adopt rules to implement and administer this section.

**SECTION 9. (1) Sections 7 and 8, chapter 886, Oregon Laws 2009, are repealed.**

**(2) The amendments to ORS 414.736 by section 6, chapter 886, Oregon Laws 2009, are repealed.**

**SECTION 10. (1) The amendments to ORS 414.826, 414.841, 414.844 and 414.851 by sections 1 to 4 of this 2011 Act become operative January 1, 2012.**

**(2) The amendments to ORS 414.743 by section 8 of this 2011 Act become operative September 1, 2011.**

**SECTION 11. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect**

**on its passage.**