Enrolled
Senate Bill 104

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)

CHAPTER ....

AN ACT

Relating to functions of the Oregon Health Authority; creating new provisions; amending ORS 414.841, 414.842, 414.844, 414.864, 414.866, 414.868, 431.385, 433.815, 433.820, 443.005, 443.019, 443.035, 443.045, 443.085, 443.100, 443.105, 443.355, 735.610, 735.615, 735.700, 735.702 and 735.710 and section 1, chapter 803, Oregon Laws 2009, and section 2, chapter 47, Oregon Laws 2010; repealing ORS 735.714; and declaring an emergency.

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

FAMILY HEALTH INSURANCE ASSISTANCE PROGRAM

SECTION 1. 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) "Eligible individual" means an individual who:

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

(b) Is not eligible for Medicare;

(c) Either 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;

(d) Except as otherwise provided by the office, has family income [*less than*] **that is 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)*] **(3)** "Family" means[*:*] **an eligible individual and all other related individuals, as prescribed by the office by rule.**

[*(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) "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 **or for dental care 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) "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)*] **(6)** "Resident" means an individual who meets the residency requirements established by rule by the office.

[*(9)*] **(7)** "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)*] **(8)** "[*Third-party*] **Third party** administrator" means any insurance company or other entity licensed under the Insurance Code to administer health insurance benefit programs.

SECTION 2. 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*] **that is 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*] **third party** administrators to administer one or more components of the Family Health Insurance Assist-

ance Program. Duties of a [*third-party*] **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*] **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 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*] **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*] **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*] **medical assistance**.

(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 **or a dental 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*] **An** individual is eligible for a subsidy for both [*the*] **a** health benefit plan and [*the*] **a** dental plan**, regardless of whether the health benefit plan provides dental coverage**.

SECTION 4. ORS 414.864 is amended to read:

414.864. (1) The Office of Private Health Partnerships [*may impose sanctions against an individual who violates*] **shall adopt by rule criteria for the recovery of an overpayment as described in ORS 411.640 of a subsidy incorrectly paid.**

(2) The office may suspend or terminate an enrollee's participation in the Family Health Insurance Assistance Program as a sanction for violating any provision of ORS 414.841 to

414.864 or rules adopted pursuant thereto[*, including but not limited to suspension or termination from the Family Health Insurance Assistance Program and repayment of any subsidy amounts paid due to the omission or misrepresentation of an applicant or enrolled individual. Sanctions allowed under this subsection shall be imposed in the manner prescribed in ORS chapter 183*].

[*(2)*] **(3)** In addition to the sanctions available pursuant to subsection [*(1)*] **(2)** of this section, the office may impose a civil penalty not to exceed $1,000 against any individual who violates any provision of ORS 414.841 to 414.864 or rules adopted pursuant thereto.

(4) Sanctions and civil penalties imposed pursuant to this section shall be imposed pursuant to ORS [*183.745*] **chapter 183**.

SECTION 5. ORS 414.866 is amended to read:

414.866. As used in ORS 414.866 to 414.872:

(1) "Benefits plan" has the meaning given that term in ORS 735.605.

(2) "Other costs" means costs incurred by the Oregon Medical Insurance Pool that are not covered by the premiums received by the pool for a subsidized member.

[*(3) "Premium" has the meaning given that term in ORS 735.700.*]

[*(4)*] **(3)** "Subsidized member" means a medical assistance program client who is enrolled in a benefits plan and who is receiving a subsidy from the Family Health Insurance Assistance Program established in ORS 414.841 to 414.864.

[*(5)*] **(4)** "Subsidy" has the meaning given that term in ORS 414.841.

SECTION 6. ORS 414.868 is amended to read:

414.868. Notwithstanding ORS 735.615 [*(3)(a) and (f)*] **(3)(b) and (g)**, a subsidized member is eligible for coverage under ORS 735.600 to 735.650.

PUBLIC HEALTH

SECTION 7. ORS 431.385 is amended to read:

431.385. (1) The local public health authority shall submit an annual plan to the Oregon Health Authority for performing services pursuant to ORS 431.375 to 431.385 and 431.416. The annual plan shall be submitted [*no later than May 1 of each year or*] on a date **established by the Oregon Health Authority by rule or on a date** mutually agreeable to the authority and the local public health authority.

(2) If the local public health authority decides not to submit an annual plan under the provisions of ORS 431.375 to 431.385 and 431.416, the authority shall become the local public health authority for that county or health district.

(3) The authority shall review and approve or disapprove each plan. Variances to the local public health plan must be approved by the authority. In consultation with the Conference of Local Health Officials, the authority shall establish the elements of a plan and an appeals process whereby a local health authority may obtain a hearing if its plan is disapproved.

(4) Each local commission on children and families shall reference the local public health plan in the local coordinated comprehensive plan created pursuant to ORS 417.775.

SECTION 8. ORS 433.815 is amended to read:

433.815. **(1)** Educational training **on the treatment of allergic responses, as** required by ORS 433.800 to 433.830**,** shall be conducted under the supervision of a physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS chapter 678 to practice in this state. The training may be conducted by a health care professional licensed under ORS chapter 678 as delegated by a supervising professional **or by an emergency medical technician meeting the requirements established by the Oregon Health Authority by rule**. The curricula shall [*minimally*] include**, at a minimum,** the following subjects:

[*(1)*] **(a)** Recognition of the symptoms of systemic allergic responses to insect stings and other allergens;

[*(2) Recognition of the symptoms of hypoglycemia;*]

[*(3)*] **(b)** Familiarity with common factors that are likely to elicit systemic allergic responses [*and common factors that may induce hypoglycemia*];

[*(4)*] **(c)** Proper administration of [*a*] **an intramuscular or** subcutaneous injection of epinephrine for severe allergic responses to insect stings and other specific allergens; **and**

[*(5) Proper administration of a subcutaneous injection of glucagon for severe hypoglycemia when other treatment has failed or cannot be initiated; and*]

[*(6)*] **(d)** Necessary follow-up treatment.

(2) Educational training on the treatment of hypoglycemia, as required by ORS 433.800 to 433.830, shall be conducted under the supervision of a physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS chapter 678 to practice in this state. The training may be conducted by a health care professional licensed under ORS chapter 678 as delegated by a supervising professional. The curricula shall include, at a minimum, the following subjects:

(a) Recognition of the symptoms of hypoglycemia;

(b) Familiarity with common factors that may induce hypoglycemia;

(c) Proper administration of a subcutaneous injection of glucagon for severe hypoglycemia when other treatment has failed or cannot be initiated; and

(d) Necessary follow-up treatment.

SECTION 9. ORS 433.820 is amended to read:

433.820. A person eligible to receive the training described in ORS 433.815 must meet the following requirements:

(1) Be [*21*] **18** years of age or older; and

(2) Have, or reasonably expect to have, responsibility for or contact with at least one other person as a result of the eligible person's occupational or volunteer status, such as camp counselors, scout leaders, school personnel, forest rangers, tour guides or chaperones.

SECTION 10. ORS 443.005 is amended to read:

443.005. As used in ORS 443.005 to 443.105:

[*(1) "Authority" means the Oregon Health Authority.*]

[*(2)*] **(1)** "Caregiver registry" means [*an agency*] **a person** that prequalifies, establishes and maintains a [*list*] **roster** of qualified private contractor caregivers that is provided to a client **or the client's representative** for **consideration in the hiring of an individual to provide** caregiver services within the client's place of residence.

[*(3)*] **(2)** "Home health agency" means a public or private agency providing coordinated home health services on a home visiting basis. "Home health agency" does not include:

(a) Any visiting nurse service or home health service conducted by and for those who rely upon spiritual means through prayer alone for healing in accordance with the tenets and practices of a recognized church or religious denomination.

(b) Those home health services offered by county health departments outside, and in addition to, programs formally designated and funded as home health agencies.

[*(4)*] **(3)** "Home health services" means items and services furnished to an individual by a home health agency, or by others under arrangements with such agency, on a visiting basis, in a place of temporary or permanent residence used as the individual's home for the purpose of maintaining that individual at home.

[*(5) "Referral agency" means an agency that prequalifies, coordinates and arranges for home health services within a client's place of residence.*]

SECTION 11. ORS 443.019 is amended to read:

443.019. (1) The Oregon Health Authority shall conduct an on-site inspection of a home health agency[*, referral agency*] and **a** caregiver registry prior to licensure and at least once every three years thereafter.

(2) In lieu of an on-site inspection, the authority may accept a certification or accreditation from a federal agency or an accrediting body approved by the authority that the state licensing standards have been met, if:

(a) The certification or accreditation is recognized by the authority as addressing the standards and conditions of participation requirements of the Centers for Medicare and Medicaid Services and any additional standards set by the authority;

(b) The agency or registry notifies the authority to participate in any exit interview conducted by the federal agency or accrediting body; and

(c) The agency or registry provides copies of all documentation concerning the certification or accreditation requested by the authority.

SECTION 12. ORS 443.035 is amended to read:

443.035. (1) The Oregon Health Authority may grant a license to a home health agency[*, referral agency*] or caregiver registry for a calendar year, may annually renew a license and may allow for a change of ownership, upon payment of a fee as follows:

(a) For a new home health agency:

(A) $1,600; and

(B) An additional $1,600 for each subunit of a parent home health agency.

(b) For renewal of a home health agency license:

(A) $850; and

(B) An additional $850 for each subunit of a parent home health agency.

(c) For a change of ownership of a home health agency at a time other than the annual renewal date:

(A) $500; and

(B) An additional $500 for each subunit of a parent home health agency.

(d) For a new [*referral agency or*] caregiver registry:

(A) $1,500; and

(B) An additional $750 for each subunit of a [*referral agency or*] caregiver registry.

(e) For renewal of a [*referral agency or*] caregiver registry license:

(A) $750; and

(B) An additional $750 for each subunit of a [*referral agency or*] caregiver registry.

(f) For a change of ownership of a [*referral agency or*] caregiver registry at a time other than the annual renewal date:

(A) $350; and

(B) An additional $350 for each subunit of a [*referral agency or*] caregiver registry.

(2) Notwithstanding subsection (1)(c) or (f) of this section, the fee for a change in ownership shall be $100 if a change in ownership does not involve:

(a) The majority owner or partner; or

(b) The administrator operating the agency or registry.

(3) All fees received pursuant to subsection (1) of this section shall be paid over to the State Treasurer and credited to the Public Health Account. Such moneys are appropriated continuously to the Oregon Health Authority for the administration of ORS 443.005 to 443.105.

SECTION 13. ORS 443.045 is amended to read:

443.045. (1) The Oregon Health Authority may deny, suspend or revoke the license of, or assess a civil penalty against, any individual, home health agency[*, referral agency*] or caregiver registry for failure to comply with ORS 443.004 or 443.005 to 443.105, or with the rules of the authority as authorized by ORS 443.085.

(2) License denials, suspensions and revocations, assessment of civil penalties, adoption of rules and judicial review thereof shall be in accordance with ORS chapter 183.

(3) A civil penalty imposed under this section may not exceed $1,000 per violation and may not total more than $2,000.

(4) All civil penalties recovered under this section shall be paid into the State Treasury and credited to the Oregon Health Authority Fund. Moneys credited to the fund under this section are continuously appropriated to the authority for the administration of ORS 443.005 to 443.105 and 443.305 to 443.350.

SECTION 14. ORS 443.085 is amended to read:

443.085. The Oregon Health Authority shall adopt rules to implement ORS 443.005 to 443.105 including, but not limited to:

(1) The qualifications of professional and ancillary personnel in order to adequately furnish home health services;

(2) Standards for the organization and quality of [*patient*] **client** care;

(3) Procedures for maintaining records;

(4) Provision for contractual arrangements for professional and ancillary health services; and

(5) Complaint and inspection procedures.

SECTION 15. ORS 443.100 is amended to read:

443.100. A person may not establish, conduct or maintain a [*referral agency or*] caregiver registry, or represent to the public that the person is a [*referral agency or*] caregiver registry, without first obtaining a [*referral agency license or*] caregiver registry license from the Oregon Health Authority.

SECTION 16. ORS 443.105 is amended to read:

443.105. The Oregon Health Authority may adopt rules governing [*referral agencies and*] caregiver registries, including but not limited to:

(1) The minimum qualifications of individuals whose services are offered through a [*referral agency or*] caregiver registry;

(2) Standards for the organization and quality of [*patient*] **client** care;

(3) Procedures for maintaining records;

(4) Requirements for contractual arrangements for professional and ancillary services;

(5) Requiring criminal background checks on individuals placed on a [*caregiver or referral list by a referral agency or*] **roster by a** caregiver registry [*or on individuals placed in a client's place of residence by a referral agency or caregiver registry*];

(6) Procedures for complaints against [*referral agencies and*] caregiver registries; and

(7) Procedures for inspection of [*referral agencies and*] caregiver registries.

SECTION 17. ORS 443.355 is amended to read:

443.355. (1) Rules adopted by the Oregon Health Authority pursuant to ORS 443.085 and 443.340 shall include procedures for the filing of complaints as to the care or services provided by home health agencies, in-home care agencies[*, referral agencies*] or caregiver registries that ensure the confidentiality of the identity of the complainant.

(2) An employee or contract provider with knowledge of a violation of law or rules of the authority shall use the reporting procedures established by the home health agency, in-home care agency[*, referral agency*] or caregiver registry before notifying the authority or other state agency of the inappropriate care or violation, unless the employee or contract provider:

(a) Believes a [*patient's*] **client's** health or safety is in immediate jeopardy; or

(b) Files a complaint in accordance with rules adopted under subsection (1) of this section.

(3) Information obtained by the authority during an investigation of a complaint or reported violation under this section is confidential and not subject to public disclosure under ORS 192.410 to 192.505. Upon the conclusion of the investigation, the authority may publicly release a report of its findings but may not include information in the report that could be used to identify the complainant or any client of the home health agency, in-home care agency[*, referral agency*] or caregiver registry. The authority may use any information obtained during an investigation in an administrative or judicial proceeding concerning the licensing of a home health agency, in-home care agency[*, referral agency*] or caregiver registry.

(4) As used in this section:

(a) "Caregiver registry" has the meaning given that term in ORS 443.005.

(b) "Home health agency" has the meaning given that term in ORS 443.005.

(c) "In-home care agency" has the meaning given that term in ORS 443.305.

[*(d) "Referral agency" has the meaning given that term in ORS 443.005.*]

SECTION 18. ORS 431.925 to 431.955 are added to and made a part of ORS 453.605 to 453.800.

OREGON MEDICAL INSURANCE POOL BOARD

SECTION 19. ORS 735.610 is amended to read:

735.610. (1) There is created in the Oregon Health Authority the Oregon Medical Insurance Pool Board. The board shall establish the Oregon Medical Insurance Pool and otherwise carry out the responsibilities of the board under ORS 735.600 to 735.650.

(2) The board shall consist of [*nine*] **10** individuals, [*seven*] **eight** of whom shall be appointed by the Director of the Oregon Health Authority. The Director of the Department of Consumer and Business Services or the director's designee and the Director of the Oregon Health Authority or the director's designee shall be members of the board. The chair of the board shall be elected from among the members of the board. The board shall at all times, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care service contractor, one representative of a health maintenance organization, one representative of reinsurers and two members of the general public who are not associated with the medical profession, a hospital or an insurer. A majority of the voting members of the board constitutes a quorum for the transaction of business. An act by a majority of a quorum is an official act of the board.

(3) The Director of the Oregon Health Authority may fill any vacancy on the board by appointment.

(4) The board shall have the general powers and authority [*granted*] under the laws of this state **granted** to insurance companies with a certificate of authority to transact health insurance and the specific authority to:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of ORS 735.600 to 735.650 including the authority to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Recover any assessments for, on behalf of, or against insurers;

(c) Take such legal action as is necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, insurance producers' referral fees, claim reserves or formulas and perform any other actuarial function appropriate to the operation of the pool. Rates may not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(e) Issue policies of insurance in accordance with the requirements of ORS 735.600 to 735.650;

(f) Appoint from among insurers appropriate actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the board;

(g) Seek advances to effect the purposes of the pool; and

(h) Establish rules, conditions and procedures for reinsuring risks under ORS 735.600 to 735.650.

(5) Each member of the board is entitled to compensation and expenses as provided in ORS 292.495.

(6) The Director of the Oregon Health Authority shall adopt rules, as provided under ORS chapter 183, implementing policies recommended by the board for the purpose of carrying out ORS 735.600 to 735.650.

(7) In consultation with the board, the Director of the Oregon Health Authority shall employ such staff and consultants as may be necessary for the purpose of carrying out responsibilities under ORS 735.600 to 735.650.

SECTION 20. ORS 735.615 is amended to read:

735.615. (1) Except as provided in subsection (3) of this section, a person who is a resident of this state, as defined by the Oregon Medical Insurance Pool Board, is eligible for medical pool coverage if:

(a) An insurer, or an insurance company with a certificate of authority in any other state, has made within a time frame established by the board an adverse underwriting decision, as defined in ORS 746.600 (1)(a)(A), (B) or (D), on individual medical insurance for health reasons while the person was a resident;

(b) The person has a history of any medical or health conditions on the list adopted by the board under subsection (2) of this section;

(c) The person is a spouse or dependent of a person described in paragraph (a) or (b) of this subsection; or

(d) The person is eligible for the credit for health insurance costs under section 35 of the federal Internal Revenue Code, as amended and in effect on December 31, 2004.

(2) The board may adopt a list of medical or health conditions for which a person is eligible for pool coverage without applying for individual medical insurance pursuant to this section.

(3) A person is not eligible for coverage under ORS 735.600 to 735.650 if:

(a) [*Except as provided in ORS 735.625 (3)(c), the person is eligible to receive health services as defined in ORS 414.705 that meet or exceed those adopted by the board or*] **Except as provided in ORS 735.625 (3) and subsection (5) of this section, the person** is eligible for Medicare;

(b) The person is eligible to receive health services as defined in ORS 414.705 that meet or exceed those adopted by the board;

[*(b)*] **(c)** The person has terminated coverage in the pool within the last 12 months and the termination was for:

(A) A reason other than becoming eligible to receive health services as defined in ORS 414.705; or

(B) A reason that does not meet exception criteria established by the board;

[*(c)*] **(d)** The person has exceeded the maximum lifetime benefit established by the board;

[*(d)*] **(e)** The person is an inmate of or a patient in a public institution named in ORS 179.321;

[*(e)*] **(f)** The person has, on the date of issue of coverage by the board, coverage under health insurance or a self-insurance arrangement that is substantially equivalent to coverage under ORS 735.625; or

[*(f)*] **(g)** The person has the premiums paid or reimbursed by a public entity or a health care provider, reducing the financial loss or obligation of the payer.

(4) A person applying for coverage shall establish initial eligibility by providing evidence that the board requires.

(5)(a) Notwithstanding ORS 735.625 (4)(c) [*and subsection (3)(a) of this section*], if a person**:**

(A) Becomes eligible for Medicare after being enrolled in the pool for a period of time as determined by the board by rule, that person may continue coverage within the pool as secondary coverage to Medicare.

(B) Is eligible for Medicare but is not yet eligible to enroll in Medicare Parts B and D, the individual may receive coverage under the pool until enrolled in Medicare Parts B and D.

(b) The board may adopt rules concerning the terms and conditions for the coverage provided under paragraph (a) of this subsection.

(6) The board may adopt rules to establish additional eligibility requirements for a person described in subsection [*(1)(d)*] **(1)(e)** of this section.

SECTION 21. Section 1, chapter 803, Oregon Laws 2009, is amended to read:

Sec. 1. Notwithstanding ORS 735.620, the Oregon Medical Insurance Pool Board is authorized to extend the three-year period of service for no more than an additional [*24*] **36** months, on terms mutually agreed upon with an insurer that is administering the insurance program or components of the insurance program pursuant to ORS 735.620 on [*the effective date of this 2009 Act*] **July 23, 2009**.

SECTION 22. Section 2, chapter 47, Oregon Laws 2010, is amended to read:

Sec. 2. (1) The Temporary High Risk Pool Program is established to ensure health insurance coverage for individuals who are uninsured and are not enrolled in the Oregon Medical Insurance Pool or other publicly funded medical assistance.

(2) The program shall be administered by the Oregon Medical Insurance Pool Board created by ORS 735.610. The board shall adopt rules for the program that are designed to obtain the maximum level of federal funding. The rules shall establish:

(a) Eligibility criteria for enrollment in the program;

(b) Health care benefits available through the program;

(c) The cost of premiums for participation in the program; and

(d) Other enrollment or benefit coverage conditions for the program.

(3) The board may limit enrollment in the program based on the anticipated federal funding and enrollee premium payments.

(4) The board has the authority to enter into contracts as necessary or proper to carry out this section.

OFFICE OF PRIVATE HEALTH PARTNERSHIPS

SECTION 23. ORS 735.700 is amended to read:

735.700. As used in ORS 735.700 to 735.714, unless the context requires otherwise:

(1) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation.

[*(2) "Eligible employee" means an employee of an employer who is employed by the employer for an average of at least 17.5 hours per week who elects to participate in one of the group benefit plans provided through action of the Office of Private Health Partnerships, and sole proprietors, business partners, and limited partners. The term does not include individuals:*]

[*(a) Engaged as independent contractors.*]

[*(b) Whose periods of employment are on an intermittent or irregular basis.*]

[*(c) Who have been employed by the employer for a period of time established by the employer or for fewer than 90 days, whichever is less.*]

[*(3)*] **(2)** "Family member" [*means an eligible employee's spouse, any unmarried child or stepchild within age limits and other conditions imposed by the office with regard to unmarried children or stepchildren, or any other dependents eligible under the terms of the health benefit plan selected by the employee's employer*] **means one of the related individuals within a family as defined in ORS 414.841**.

[*(4)*] **(3)** "Health benefit plan" [*means a contract for group medical, surgical, hospital or any other remedial care recognized by state law and related services and supplies*] **has the meaning given that term in ORS 414.841**.

[*(5) "Premium" means the monthly or other periodic charge for a health benefit plan.*]

[*(6) "Small employer" means a person, firm, corporation, partnership or association actively engaged in business that, on at least 50 percent of its working days during the preceding year, employed no more than 50 eligible employees and no fewer than two eligible employees, the majority of whom are employed within this state, and in which a bona fide partnership or employer-employee relationship exists. "Small employer" includes corporations that are eligible to file a consolidated tax return pursuant to ORS 317.715.*]

SECTION 24. ORS 735.702 is amended to read:

735.702. To increase access to health insurance and health care, the Office of Private Health Partnerships shall provide:

(1) Information about health benefit plans and the premiums charged for those plans to self-employed individuals and [*small*] employers in Oregon;

(2) Direct assistance to health insurance producers and health insurance consumers regarding health benefit plans; **and**

(3) A central source for information about resources for health care and health insurance**.**[*; and*]

[*(4) Health benefit plans for small employers that have not provided a group health benefit plan for eligible employees for a period of at least one year.*]

SECTION 25. ORS 735.710 is amended to read:

735.710. (1) In carrying out its duties under ORS 414.841 to 414.864 and 735.700 to 735.714, the Office of Private Health Partnerships [*shall*] **may**:

(a) Enter into contracts for administration of ORS 414.841 to 414.864 and 735.700 to 735.714, including collection of premiums and paying carriers.

(b) Retain consultants and employ staff.

(c) Enter into contracts with carriers or health care providers for health benefit plans **for individuals and employers**, including contracts where final payment may be reduced if usage is below a level fixed in the contract.

[*(d) Set premium rates for eligible employees and small employers.*]

[*(e)*] **(d)** Perform other duties to provide low-cost health benefit plans of types likely to be purchased by **individuals and** [*small*] employers.

[*(f) Establish contributions to be paid by small employers toward the premiums incurred on behalf of covered eligible employees.*]

[*(g)*] **(2) The office shall** establish procedures by rule for the publication or release of aggregate data relating to:

[*(A)*] **(a)** Applicants for enrollment and persons enrolled in the Family Health Insurance Assistance Program;

[*(B)*] **(b)** Health benefit plans for [*small*] **individuals and** employers offered by the office; and

[*(C)*] **(c)** Other programs operated by the office.

(3) With respect to health benefit plans contracted for or certified by the office under ORS 414.841 to 414.864 or 735.700 to 735.714, the office:

[*(2)*] **(a)** [*Notwithstanding any other health benefit plan contracted for and offered by the office, the office*] Shall contract for [*a*] **or certify** health benefit [*plan or*] plans best designed to meet the needs and provide for the welfare of **individuals,** [*eligible*] employees and [*small*] employers.

[*(3)*] **(b)** [*The office*] May approve more than one carrier for each type of plan contracted for [*and offered*] **or certified**, but the number of carriers shall be held to a number consistent with adequate service to [*eligible employees and family members*] **enrollees**.

(c) May approve premium rates for health benefit plans for individuals and employers and may establish contributions to be paid by employers toward the premiums incurred on behalf of covered employees.

[*(4)*] **(d) Shall,** where appropriate for a contracted and offered health benefit plan, [*the office shall*] provide options under which an [*eligible*] employee may arrange coverage for family members of the employee.

[*(5)*] **(e)** [*In developing any health benefit plan, the office*] May provide an option of additional coverage for [*eligible*] employees and family members at an additional cost or premium.

[*(6)*] **(f) Shall, by rule, establish a method for all enrollees to** transfer [*of*] enrollment from one health benefit plan to another [*shall be open to all eligible employees and family members under rules adopted by the office*].

[*(7)*] **(g)** [*If the office requests less health care service or benefit*] **May require coverage of fewer health care services or benefits** than is otherwise required by state law[*, a carrier is not required to offer such service or benefit*].

[*(8)*] **(h) Shall require** health benefit plans [*for small employers contracted for and offered*] **certified** by the office **for the Family Health Insurance Assistance Program or offered in the private health option under ORS 414.826 to** [*must*] provide a sufficient level of benefits to be eligible for a subsidy under ORS 414.844.

[*(9)*] **(4)** The office may employ whatever means are reasonably necessary to carry out the purposes of ORS 414.841 to 414.864 and 735.700 to 735.714. Such authority includes but is not limited to authority to seek clarification, amendment, modification, suspension or termination of any agreement**,** [*or*] contract **or certification** that in the office's judgment requires such action.

SECTION 26. ORS 735.714 is repealed.

UNIT CAPTIONS

SECTION 27. The unit captions used in this 2011 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 2011 Act.

EMERGENCY CLAUSE

SECTION 28. 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.

Passed by Senate February 10, 2011

....
Robert Taylor, Secretary of Senate

....
Peter Courtney, President of Senate

Passed by House May 11, 2011

....
Bruce Hanna, Speaker of House

....
Arnie Roblan, Speaker of House

Received by Governor:

........................M.,..., 2011

Approved:

........................M.,..., 2011

....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

........................M.,..., 2011

....
Kate Brown, Secretary of State