A-Engrossed
Senate Bill 88

Ordered by the Senate March 17
Including Senate Amendments dated March 17

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Governor John A. Kitzhaber for Department of Consumer and Business Services)

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.

Requires Director of Department of Consumer and Business Services to adopt prompt payment requirements for long term care insurance.

Requires Director of Department of Consumer and Business Services to adopt internal and external review procedures for denial of long term care insurance claims. [*Requires insurer to notify insured of review procedures. Extends prompt payment requirements and interest on unpaid claims for health benefit plans to long term care insurers.*]

Requires long term care insurance policies to include clear description of process for appealing and resolving disputes regarding denial of claims.

Declares emergency, effective on passage.

1 **A BILL FOR AN ACT**

2 Relating to long term care insurance; creating new provisions; amending ORS 414.025, 743.652,
3 743.653, 743.655 and 743.664; and declaring an emergency.

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

5 **SECTION 1. Section 2 of this 2011 Act is added to and made a part of ORS 743.650 to**
6 **743.664.**

7 **SECTION 2. The Director of the Department of Consumer and Business Services shall**
8 **adopt by rule prompt payment requirements for long term care insurance. The rules shall**
9 **include a definition of "claim" and a definition of "clean claim." In adopting the rules, the**
10 **director shall consider the prompt payment requirements in long term care insurance model**
11 **acts developed by the National Association of Insurance Commissioners.**

12 **SECTION 3.** ORS 743.652 is amended to read:

13 743.652. As used in ORS 743.650 to 743.664, unless the context requires otherwise:

14 (1) "Applicant" means:

15 (a) In the case of an individual long term care insurance policy, the person who seeks to con-
16 tract for benefits; and

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

18 **(2) "Benefit trigger" means a contractual provision in a long term care insurance policy**
19 **that conditions the payment of benefits on an insured's inability to perform activities of daily**
20 **living or on an insured's cognitive impairment. For qualified long term care insurance, the**
21 **"benefit trigger" is the determination that an insured is a chronically ill individual, as de-**
22 **fined in section 7702B(c) of the Internal Revenue Code.**

23 [*(2)*] **(3)** "Certificate" means any certificate issued under a group long term care insurance pol-

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.

icy, if the policy has been delivered or issued for delivery in this state.

[*(3)*] **(4)** "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;

(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;

(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 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 the filing, the association or associations shall be considered to satisfy the organizational requirements, unless the director makes a finding that the association or associations do not satisfy those organizational requirements; 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.

[*(4)*] **(5)** "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 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 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" does not include any insurance policy 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 743.664, any product advertised, marketed or offered as long term care insurance is subject to ORS 743.650 to 743.664.

[*(5)*] **(6)** "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)*] **(7)** "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.

1 **SECTION 4.** ORS 743.653 is amended to read:
2 743.653. Group long term care insurance coverage may not be offered to a resident of this state
3 under a group policy issued in another state to a group described in ORS 743.652 [*(3)(d)*] **(4)(d)**,
4 unless this state or another state having statutory and regulatory long term care insurance re-
5 quirements substantially similar to those adopted in this state has made a determination that such
6 requirements have been met.
7 **SECTION 5.** ORS 743.655 is amended to read:
8 743.655. (1)(a) The Director of the Department of Consumer and Business Services shall adopt
9 rules that include standards for full and fair disclosure setting forth the manner, content and re-
10 quired disclosures for the sale of long term care insurance policies, terms of renewability, initial and
11 subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents,
12 preexisting conditions, termination of insurance, program for public understanding, continuation or
13 conversion, probationary periods, limitations, exceptions, reductions, elimination periods, underwrit-
14 ing at time of application, requirements for replacement, recurrent conditions and definitions of
15 terms **and that include required procedures for internal and external review of whether the**
16 **conditions of a benefit trigger have been met**.
17 (b) In adopting rules [*setting standards*] under this section, the Director **of the Department of**
18 **Consumer and Business Services** must give timely notice to, and shall consider recommendations
19 from the Director of Human Services.
20 (2) A long term care insurance policy may not:
21 (a) Be canceled, nonrenewed or otherwise terminated on the grounds of the age or the deteri-
22 oration of the mental or physical health of the insured individual or certificate holder;
23 (b) Contain a provision establishing a new waiting period in the event existing coverage is
24 converted to or replaced by a new or other form within the same company, except with respect to
25 an increase in benefits voluntarily selected by the insured individual or group policyholder;
26 (c) Provide coverage for skilled nursing care only or provide significantly more coverage for
27 skilled care in a facility than coverage for lower levels of care;
28 (d) Exclude coverage for Alzheimer's disease and related dementias;
29 (e) Be nonrenewed or otherwise terminated for nonpayment of premiums until 31 days overdue
30 and then only after notice of nonpayment is given the policyholder prior to expiration of the 31 days,
31 except as otherwise provided by rule; or
32 (f) Be sold to provide less than 24 months' coverage.
33 (3)(a) A long term care insurance policy or certificate other than a policy or certificate issued
34 to a group described in ORS 743.652 [*(3)(a)*] **(4)(a)**, (b) or (c) may not use a definition of "preexisting
35 condition" that is more restrictive than the following: "Preexisting condition" means a condition for
36 which medical advice or treatment was recommended by, or received from a provider of health care
37 services, within six months preceding the effective date of coverage of an insured person.
38 (b) A long term care insurance policy or certificate other than a policy or certificate thereunder
39 issued to a group described in ORS 743.652 [*(3)(a)*] **(4)(a)**, (b) or (c) may not exclude coverage for a
40 loss or confinement that is the result of a preexisting condition unless the loss or confinement be-
41 gins within six months following the effective date of coverage of an insured person.
42 (c) The Director of the Department of Consumer and Business Services may extend the limita-
43 tion periods set forth in paragraphs (a) and (b) of this subsection as to specific age group categories
44 or specific policy forms upon findings that the extension is in the best interest of the public.
45 (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. 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.

(4) A long term care insurance policy 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;

(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.

(6) Individual long term care insurance 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 applicant is not satisfied for any reason. Long term care insurance policies and certificates must have a notice prominently printed on the first page or attached thereto stating in substance that the 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 or certificate, other than a certificate issued pursuant to a policy issued to a group described in ORS 743.652 [*(3)(a)*] **(4)(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.

(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 that prominently direct the attention of the recipient to the document and its purpose.

(B) The Director **of the Department of Consumer and Business Services** by rule must prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(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.

(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)*] **(4)(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 **of the Department of Consumer and Business Services**.

(b) The outline of coverage 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;

(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.

(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 **personal or authorized** 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.

(13) Long term care insurance policies shall include a clear description of the process for appealing and resolving disputes regarding whether the conditions of a benefit trigger have been met.

[*(13)*] **(14)** 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 743.664.

[*(14)*] **(15)** Rules adopted pursuant to ORS 743.650 to 743.664 shall be in accordance with the provisions of ORS chapter 183.

[*(15)*] **(16)** This section is exempt from ORS 743A.001.

SECTION 6. ORS 743.664 is amended to read:

743.664. (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)*] **(4)(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 743A.001.

SECTION 7. 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,

1 aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income
2 payments.
3 (2) "Categorically needy" means, insofar as funds are available for the category, a person who
4 is a resident of this state and who:
5 (a) Is receiving a category of aid.
6 (b) Would be eligible for a category of aid but is not receiving a category of aid.
7 (c) Is in a medical facility and, if the person left such facility, would be eligible for a category
8 of aid.
9 (d) Is under the age of 21 years and would be a dependent child as defined in ORS 412.001 except
10 for age and regular attendance in school or in a course of professional or technical training.
11 (e)(A) Is a caretaker relative, as defined in ORS 412.001, who cares for a child who would be a
12 dependent child except for age and regular attendance in school or in a course of professional or
13 technical training; or
14 (B) Is the spouse of the caretaker relative.
15 (f) Is under the age of 21 years and:
16 (A) Is in a foster family home or licensed child-caring agency or institution and is one for whom
17 a public agency of this state is assuming financial responsibility, in whole or in part; or
18 (B) Is 18 years of age or older, is one for whom federal financial participation is available under
19 Title XIX or XXI of the federal Social Security Act and who met the criteria in subparagraph (A)
20 of this paragraph immediately prior to the person's 18th birthday.
21 (g) Is a spouse of an individual receiving a category of aid and who is living with the recipient
22 of a category of aid, whose needs and income are taken into account in determining the cash needs
23 of the recipient of a category of aid, and who is determined by the Department of Human Services
24 to be essential to the well-being of the recipient of a category of aid.
25 (h) Is a caretaker relative as defined in ORS 412.001 who cares for a dependent child receiving
26 aid granted under ORS 412.001 to 412.069 and 418.647 or is the spouse of the caretaker relative.
27 (i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency
28 of this state is assuming financial responsibility, in whole or in part.
29 (j) Is under the age of 21 years and is in an intermediate care facility which includes institutions
30 for persons with mental retardation.
31 (k) Is under the age of 22 years and is in a psychiatric hospital.
32 (L) Is under the age of 21 years and is in an independent living situation with all or part of the
33 maintenance cost paid by the Department of Human Services.
34 (m) Is a member of a family that received aid in the preceding month under ORS 412.006 or
35 412.014 and became ineligible for aid due to increased hours of or increased income from employ-
36 ment. As long as the member of the family is employed, such families will continue to be eligible for
37 medical assistance for a period of at least six calendar months beginning with the month in which
38 such family became ineligible for assistance due to increased hours of employment or increased
39 earnings.
40 (n) Is an adopted person under 21 years of age for whom a public agency is assuming financial
41 responsibility in whole or in part.
42 (o) Is an individual or is a member of a group who is required by federal law to be included in
43 the state's medical assistance program in order for that program to qualify for federal funds.
44 (p) Is an individual or member of a group who, subject to the rules of the department, may op-
45 tionally be included in the state's medical assistance program under federal law and regulations

1 concerning the availability of federal funds for the expenses of that individual or group.
2 (q) Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to 412.069 and
3 418.647, whether or not the woman is eligible for cash assistance.
4 (r) Except as otherwise provided in this section, is a pregnant woman or child for whom federal
5 financial participation is available under Title XIX or XXI of the federal Social Security Act.
6 (s) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the
7 federal Social Security Act or is not a full-time student in a post-secondary education program as
8 defined by the Department of Human Services by rule, but whose family income is less than the
9 federal poverty level and whose family investments and savings equal less than the investments and
10 savings limit established by the department by rule.
11 (t) Would be eligible for a category of aid but for the receipt of qualified long term care insur-
12 ance benefits under a policy or certificate issued on or after January 1, 2008. As used in this para-
13 graph, "qualified long term care insurance" means a policy or certificate of insurance as defined in
14 ORS 743.652 [*(6)*] **(7)**.
15 (u) Is eligible for the Health Care for All Oregon Children program established in ORS 414.231.
16 (3) "Income" has the meaning given that term in ORS 411.704.
17 (4) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable in-
18 struments as defined in ORS 73.0104 and such similar investments or savings as the Department of
19 Human Services may establish by rule that are available to the applicant or recipient to contribute
20 toward meeting the needs of the applicant or recipient.
21 (5) "Medical assistance" means so much of the following medical and remedial care and services
22 as may be prescribed by the Oregon Health Authority according to the standards established pur-
23 suant to ORS 413.032, including payments made for services provided under an insurance or other
24 contractual arrangement and money paid directly to the recipient for the purchase of medical care:
25 (a) Inpatient hospital services, other than services in an institution for mental diseases;
26 (b) Outpatient hospital services;
27 (c) Other laboratory and X-ray services;
28 (d) Skilled nursing facility services, other than services in an institution for mental diseases;
29 (e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled
30 nursing facility or elsewhere;
31 (f) Medical care, or any other type of remedial care recognized under state law, furnished by
32 licensed practitioners within the scope of their practice as defined by state law;
33 (g) Home health care services;
34 (h) Private duty nursing services;
35 (i) Clinic services;
36 (j) Dental services;
37 (k) Physical therapy and related services;
38 (L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter
39 689;
40 (m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases
41 of the eye or by an optometrist, whichever the individual may select;
42 (n) Other diagnostic, screening, preventive and rehabilitative services;
43 (o) Inpatient hospital services, skilled nursing facility services and intermediate care facility
44 services for individuals 65 years of age or over in an institution for mental diseases;
45 (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 8. (1) Section 2 of this 2011 Act and the amendments to ORS 743.652, 743.653, 743.655 and 743.664 by sections 3 to 6 of this 2011 Act apply to long term care insurance policies issued or renewed on or after July 1, 2012.

(2) The Director of the Department of Consumer and Business Services may take any action necessary after the effective date of this 2011 Act to fully implement section 2 of this 2011 Act and the amendments to ORS 743.652, 743.653, 743.655 and 743.664 by sections 3 to 6 of this 2011 Act on July 1, 2012.

SECTION 9. 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.