House Bill 4154

Sponsored by Representative FAGAN; Representatives KOMP, VEGA PEDERSON (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires Oregon Health Insurance Exchange Corporation to request federal approval to take specified steps to protect Oregon residents and businesses from consequences of operational delays in Cover Oregon website. Expands authority of Governor to remove members of board of directors of Oregon Health Insurance Exchange Corporation.

Makes employees of Cover Oregon subject to state whistleblower protections.

Authorizes Oregon Medical Insurance Pool Board to make expenditures for transitional medical insurance pool program.

Modifies requirements for Oregon Reinsurance Program to align with changes in federal law.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to administration of health insurance; creating new provisions; amending ORS 659A.200, 735.612 and 741.025 and section 2, chapter 698, Oregon Laws 2013; and declaring an emergency.

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

SECTION 1. No later than the effective date of this 2014 Act, the Oregon Health Insurance Exchange Corporation shall request the appropriate federal agency to:

(1) Extend the open enrollment period, for residents of this state to enroll in health plans, to April 30, 2014;

(2) Pay premium tax credits and cost-saving reductions to Oregon residents who:

(a) Were not able to enroll in a qualified health plan through the health insurance exchange due to technical problems with the health insurance exchange website;

(b) Enrolled in a qualified health plan offered through the exchange by enrolling directly with an insurer or with the assistance of an insurance producer, during the open enrollment period or any extension of the open enrollment period; and

(c) Would qualify for premium tax credits or cost-sharing reductions but for the inability to enroll in a qualified health plan through the exchange.

(3) Extend the transition relief described in Internal Revenue Notice 2014-6 to small employers that have principal business addresses in Oregon to allow them to claim the business tax credit under section 45R of the Internal Revenue Code for tax year 2014.

SECTION 2. ORS 659A.200 is amended to read:

659A.200. As used in ORS 659A.200 to 659A.224:

(1) "Disciplinary action" includes but is not limited to any discrimination, dismissal, demotion, transfer, reassignment, supervisory reprimand, warning of possible dismissal or withholding of work, whether or not the action affects or will affect employee compensation.

(2) "Employee" means a person [*employed by or under contract with*]:

(a) **Employed by or under contract with** the state or any agency of or political subdivision in the state;

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.

(b) **Employed by or under contract with** any person authorized to act on behalf of the state, or agency of the state or subdivision in the state, with respect to control, management or supervision of any employee;

(c) [*Employees of*] **Employed by** the public corporation created under ORS 656.751;

(d) Employed by the public corporation established under ORS 741.001;

[*(d)*] **(e)** [*Employees of*] **Employed by** a contractor who performs services for the state, agency or subdivision, other than employees of a contractor under contract to construct a public improvement; and

[*(e)*] **(f) Employed by or under contract with** any person authorized by contract to act on behalf of the state, agency or subdivision.

(3) "Public employer" means:

(a) The state or any agency of or political subdivision in the state; and

(b) Any person authorized to act on behalf of the state, or any agency of or political subdivision in the state, with respect to control, management or supervision of any employee.

SECTION 3. ORS 735.612 is amended to read:

735.612. (1) There is established in the State Treasury, the Oregon Medical Insurance Pool Account, which shall consist of:

(a) Moneys appropriated to the account by the Legislative Assembly.

(b) Interest earnings from the investment of moneys in the account.

(c) Assessments and other revenues collected or received by the Oregon Medical Insurance Pool Board.

(2) All moneys in the Oregon Medical Insurance Pool Account are continuously appropriated to the Oregon Medical Insurance Pool Board to carry out the provisions of ORS 735.600 to 735.650 and sections 1, 2 and 4, chapter 698, Oregon Laws 2013**, and for programs administered by the board that facilitate health insurance coverage for individuals who were enrolled in pool coverage under ORS 735.600 to 735.650 on December 31, 2013**.

(3) The Oregon Medical Insurance Pool Board shall transfer to the Oregon Health Authority Fund established in ORS 413.101 an amount equal to the operating budget authorized by the Legislative Assembly or as that budget may be modified by the Emergency Board or the Oregon Department of Administrative Services, for operation of the Oregon Medical Insurance Pool Board.

SECTION 4. ORS 741.025 is amended to read:

741.025. (1) The Oregon Health Insurance Exchange Corporation shall be governed by a board of directors consisting of two ex officio members and seven members who are appointed by the Governor and subject to confirmation by the Senate in the manner prescribed by ORS 171.562 and 171.565.

(2) The ex officio voting members of the board are:

(a) The Director of the Oregon Health Authority or the director's designee; and

(b) The Director of the Department of Consumer and Business Services or the director's designee.

(3)(a) The term of office of each member who is not an ex officio member is four years. The Governor may remove any member at any time for incompetence, neglect of duty or malfeasance in office, after notice and a hearing that shall be open to the public[*, but the Governor may not remove more than three members within any four-year period except for corrupt conduct in office*].

(b) Before the expiration of the term of a member who is not an ex officio member, the Governor shall appoint a successor whose term begins on January 1 next following. A member who is not an

ex officio member is eligible for no more than two reappointments. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(4) The members who are not ex officio members must be individuals who:

(a) Are United States citizens and residents of the State of Oregon;

(b) Have demonstrated professional and community leadership skills and experience;

(c) To the greatest extent practicable, represent the geographic, ethnic, gender, racial and economic diversity of this state; and

(d) Subject to subsections (5) and (6) of this section, collectively offer expertise, knowledge and experience in individual insurance purchasing, business, finance, sales, health benefits administration, individual and small group health insurance and use of the health insurance exchange.

(5) No more than two of the members who are not ex officio members may be individuals who are:

(a) Employed by, consultants to or members of a board of directors of:

(A) An insurer or third party administrator;

(B) An insurance producer; or

(C) A health care provider, health care facility or health clinic;

(b) Members, board members or employees of a trade association of:

(A) Insurers or third party administrators; or

(B) Health care providers, health care facilities or health clinics; or

(c) Health care providers, unless they receive no compensation for rendering services as health care providers and do not have ownership interests in professional health care practices.

(6)(a) At least two of the members who are not ex officio members shall be consumer members.

(b) One consumer member must be an individual consumer purchasing a qualified health plan through the exchange.

(c) One consumer member must be a small business employer purchasing a qualified health plan through the exchange.

(7) The board of directors shall adopt a formal business plan for the corporation, which shall include a plan for developing metrics to measure customer service and provider satisfaction, and shall establish the policies for the operation of the exchange, consistent with state and federal law.

SECTION 5. Section 2, chapter 698, Oregon Laws 2013, as amended by section 32, chapter 722, Oregon Laws 2013, is amended to read:

Sec. 2. (1) As used in this section, section 1, chapter 698, Oregon Laws 2013, and ORS 735.610:

(a) "Health benefit plan" has the meaning given that term in ORS 743.730.

(b) "Insurer" means an insurer described in ORS 735.605 (4)(a), (b) and (d).

(c) "National attachment point" means the attachment point set forth in the United States Department of Health and Human Services' annual notice of benefit and payment parameters, in accordance with 45 C.F.R. 153.230.

(d) "National coinsurance rate" means the reinsurance rate set forth in the United States Department of Health and Human Services' annual notice of benefit and payment parameters, in accordance with 45 C.F.R. 153.230.

(e) "National reinsurance cap" means the reinsurance cap set forth in the United States Department of Health and Human Services' annual notice of benefit and payment parameters, in accordance with 45 C.F.R. 153.230.

[*(c)*] **(f)** "Program" means the Oregon Reinsurance Program established in section 1, chapter 698,

Oregon Laws 2013.

[*(d)*] **(g)** "Reinsurance eligible health benefit plan" means a health benefit plan providing individual coverage that:

(A) Is delivered or issued for delivery in this state;

(B) Is not a grandfathered health plan as defined in ORS 743.730; and

(C) Meets the criteria prescribed by the Oregon Medical Insurance Pool Board under subsection (2) of this section.

[*(e)*] **(h)** "Reinsurance eligible individual" means an individual who is insured [*on or before April 1, 2014,*] under a reinsurance eligible health benefit plan**, on or before the first day of the month immediately following the close of the initial open enrollment period described in 42 U.S.C. 18031(c)(6) and established by rule or by guidance by the United States Department of Health and Human Services,** and who was:

(A) On December 31, 2013, enrolled in the Oregon Medical Insurance Pool created in ORS 735.610;

(B) On June 30, 2013, enrolled in the Temporary High Risk Pool Program established in section 1, chapter 47, Oregon Laws 2010;

(C) On December 31, 2013, insured under a portability health benefit plan as defined in ORS 743.760; or

(D) On December 31, 2013, reinsured under the reinsurance program for children's coverage described in ORS 735.614 (1)(b).

(i) "State attachment point" means the threshold dollar amount for claims costs incurred by an insurer for an insured individual's covered benefits in a benefit year, after which threshold the claims costs for the benefits are eligible for reinsurance payments.

(j) "State coinsurance rate" means the rate at which the Oregon Medical Insurance Pool Board will reimburse a reinsurance eligible health benefit plan for claims costs incurred for an insured individual's covered benefits in a benefit year after the state attachment point and before the state reinsurance cap.

(k) "State reinsurance cap" means the threshold dollar amount for claims costs incurred by a reinsurance eligible health benefit plan for an insured individual's covered benefits, after which threshold the claims costs for the benefits are no longer eligible for reinsurance payments.

(2) The board shall prescribe by rule the criteria for a health benefit plan to qualify for reinsurance payments under the program. The criteria must be consistent with requirements for:

(a) Premium rates under 42 U.S.C. 300gg;

(b) Guaranteed availability under 42 U.S.C. 300gg-1;

(c) Guaranteed renewability under 42 U.S.C. 300gg-2;

(d) Coverage of essential health benefits under 42 U.S.C. 18022; and

(e) Using a single risk pool under 42 U.S.C. 18032(c).

(3) An issuer of a reinsurance eligible health benefit plan becomes eligible for a reinsurance payment when the claims costs for a reinsurance eligible individual's covered benefits in a calendar year exceed the **state** attachment point. The amount of the payment shall be the product of the **state** coinsurance rate and the issuer's claims costs for the reinsurance eligible individual's claims costs that exceed the **state** attachment point, up to the **state** reinsurance cap, as follows:

(a) For 2014:

(A) The **state** attachment point is $30,000.

(B) The **state** reinsurance cap is $300,000.

(C) Except as provided in paragraph (b) of this subsection, the **state** coinsurance rate is:

(i) [*Ten percent*] For claims costs above [*$60,000*] **the national attachment point** and up to and including [*$250,000*] **the national reinsurance cap:**

(I) If the national coinsurance rate is at or above 90 percent of the claims costs, zero percent; or

(II) If the national coinsurance rate is below 90 percent of the claims costs, the difference between 90 percent of the claims costs and the national coinsurance rate; and

(ii) Ninety percent for claims costs**:**

(I) [*from $30,000 and up to and including $60,000 and above $250,000*] **From the state attachment point up to and including the national attachment point; and**

(II) From the national reinsurance cap up to and including the state reinsurance cap.

(b) The board may lower the **state** coinsurance rate if the reinsurance claims incurred exceed the total amount of the assessments collected under subsection (4) of this section.

(c) The board shall adopt by rule [*an*] **a state** attachment point, **state** reinsurance cap and **state** coinsurance rate for calendar years 2015 and 2016 that complement the federal reinsurance program requirements, so that the reinsurance claims do not exceed the total amount of the assessments collected under subsection (4) of this section. After the rules required under this paragraph are adopted for a calendar year, the board may not:

(A) Change the **state** attachment point or the **state** reinsurance cap adopted for that calendar year; or

(B) Increase the **state** coinsurance rate adopted for that calendar year.

(4) The board shall impose an assessment on all insurers at a rate that is expected to produce**, at a minimum,** an amount of funds sufficient to pay administrative expenses and to make reinsurance payments that are due to issuers of reinsurance eligible health benefit plans in a calendar year, but not greater than the rate that would be expected to produce funds totaling the lesser of:

(a) An amount per month multiplied by the number of insureds and certificate holders in this state who are insured or reinsured; or

(b) The total assessment set forth in subsection (5) of this section.

(5) The amount per month and total assessment on all insurers are as follows:

(a) For calendar year 2014, the amount per month is $4 and the total assessment is $72 million.

(b) For calendar year 2015, the amount per month is $3.50 and the total assessment is $63 million.

(c) For calendar year 2016, the amount per month is $2.20 and the total assessment is $40 million.

(6) In determining the number of insureds and certificate holders in this state who are insured or reinsured, the board shall exclude individuals with the following types of coverage:

(a) The medical assistance program under ORS chapter 414;

(b) Medicare;

(c) Disability income insurance;

(d) Hospital-only insurance;

(e) Dental-only insurance;

(f) Vision-only insurance;

(g) Accident-only insurance;

(h) Automobile insurance;

(i) Specific disease insurance;

(j) Medical supplemental plans;

(k) TRICARE;

(L) Prescription drug only plans;

(m) Long term care insurance; and

(n) Federal Employees Health Benefits Program.

(7) If the board collects assessments that exceed the amount necessary to pay administrative expenses and to make all of the reinsurance payments that are due to issuers of reinsurance eligible health benefit plans in calendar years 2014, 2015 and 2016, the board shall refund the excess, on a pro rata basis, to insurers who are subject to the assessment imposed by subsection (4) of this section.

(8) The board may not impose an assessment under subsection (4) of this section for calendar years beginning with 2017.

(9) All moneys received or collected by the board under this section shall be paid into the Oregon Medical Insurance Pool Account established in ORS 735.612.

(10) The board, in consultation with the Department of Consumer and Business Services, may adopt rules necessary to carry out the provisions of this section including, but not limited to, rules prescribing:

(a) The eligibility requirements for participation in the program by an issuer of a reinsurance eligible health benefit plan;

(b) The form and manner of issuing notices of assessment amounts;

(c) The amount, manner and frequency of the payment and collection of assessments;

(d) The amount, manner and frequency of reinsurance payments; and

(e) Reporting requirements for insurers subject to the assessment and for issuers of reinsurance eligible health benefit plans.

SECTION 6. This 2014 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2014 Act takes effect on its passage.
