HB 4154-15
(LC 219)
2/12/14 (LHF/ps)

**PROPOSED AMENDMENTS TO**
**HOUSE BILL 4154**

On page 1 of the printed bill, line 2, after "amending" delete the rest of the line and delete line 3 and insert "ORS 243.129, 243.142, 243.867, 243.886, 291.229, 291.231, 351.094, 411.400, 411.402, 411.406, 413.011, 413.017, 413.032, 413.037, 413.085, 414.115, 414.826, 659A.200, 735.612, 743.730, 743.733, 743.822 and 743.826 and section 11, chapter 8, Oregon Laws 2012, section 2, chapter 698, Oregon Laws 2013, and section 1, chapter 712, Oregon Laws 2013; repealing ORS 741.001, 741.002, 741.025, 741.027, 741.029, 741.031, 741.101, 741.105, 741.201, 741.220, 741.222, 741.250, 741.255, 741.300, 741.310, 741.340, 741.381, 741.390, 741.400, 741.500, 741.510, 741.520, 741.540 and 741.900 and section 27, chapter 415, Oregon Laws 2011, section 14, chapter 38, Oregon Laws 2012, and section 4, chapter 368, Oregon Laws 2013; and declaring an emergency.".

Delete lines 5 through 19 and insert:

**"SECTION 1. The Oregon Health Authority shall request a waiver from the appropriate federal agencies to permit individuals to purchase qualified health plans, as defined in 42 U.S.C. 18021, directly from insurers and to qualify for premium tax credits, under section 36B of the Internal Revenue Code, and cost-sharing reductions under 42 U.S.C. 18071, if the individual:**

**"(1) Is under the age of 65;**

**"(2) Has family income below 400 percent of the federal poverty line;**

**"(3) Would not have qualified for medical assistance under 42 U.S.C.**

**1396a as in effect on December 31, 2013; and**

**"(4) Would qualify for premium tax credits or cost-sharing reductions but for the individual's purchase of a health plan directly from an insurer.**

**"SECTION 2. (1) The Oregon Health Insurance Exchange Corporation is abolished. On the operative date of this section, the tenure of office of the members of the board of directors of the corporation and of the executive director of the corporation ceases.**

**"(2) All the duties, functions and powers of the corporation are imposed upon, transferred to and vested in the Oregon Health Authority.**

**"(3) The functions of the executive director of the corporation are transferred to the Director of the Oregon Health Authority.**

**"SECTION 3. The Oregon Health Insurance Exchange Corporation shall transfer to the Oregon Health Authority ownership of accounts established under ORS 741.101. The authority shall cease the imposition of charges and fees under ORS 741.105. The authority shall return all moneys received in federal grants to the appropriate federal agency and shall use the nonfederal moneys in the accounts to take all necessary steps to cease the operation of the Oregon Health Insurance Exchange Corporation and the health insurance exchange.**

**"SECTION 4. (1) The executive director of the Oregon Health Insurance Exchange Corporation shall:**

**"(a) Deliver to the Oregon Health Authority all records and property within the jurisdiction of the executive director that relate to the duties, functions and powers transferred by section 2 of this 2014 Act; and**

**"(b) Transfer to the authority those employees engaged primarily in the exercise of the duties, functions and powers transferred by section 2 of this 2014 Act.**

**"(2) The Director of the Oregon Health Authority shall take possession of the records and property, and may take charge of the employees and employ them in the exercise of the duties, functions and powers transferred by section 2 of this 2014 Act, subject to change or termination of employment or compensation as the director deems necessary.**

**"(3) The Governor shall resolve any dispute between the corporation and the authority relating to transfers of records, property and employees under this section, and the Governor's decision is final.**

**"SECTION 5. The transfer of duties, functions and powers to the Oregon Health Authority by section 2 of this 2014 Act does not affect any action, proceeding or prosecution involving or with respect to such duties, functions and powers begun before and pending at the time of the transfer, except that the authority is substituted for the Oregon Health Insurance Exchange Corporation in the action, proceeding or prosecution.**

**"SECTION 6. (1) Nothing in sections 2 to 10 of this 2014 Act or the repeal of ORS 741.001, 741.002, 741.025, 741.027, 741.029, 741.031, 741.101, 741.105, 741.201, 741.220, 741.222, 741.250, 741.255, 741.300, 741.310, 741.340, 741.381, 741.390, 741.400, 741.500, 741.510, 741.520, 741.540 and 741.900 by section 39 of this 2014 Act relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions and powers transferred by section 2 of this 2014 Act. The Oregon Health Authority may undertake the collection or enforcement of any such liability, duty or obligation.**

**"(2) The rights and obligations of the Oregon Health Insurance Exchange Corporation legally incurred under contracts, leases and business transactions executed, entered into or begun before the operative date of section 2 of this 2014 Act are transferred to the authority. For the purpose of succession to these rights and obligations, the authority**

**is a continuation of the corporation and not a new authority.**

**"SECTION 7. Notwithstanding the transfer of duties, functions and powers by section 2 of this 2014 Act, the rules of the Oregon Health Insurance Exchange Corporation in effect on the operative date of section 2 of this 2014 Act continue in effect until repealed by the Oregon Health Authority. References in rules of the corporation to the corporation or an officer or employee of the corporation are considered to be references to the authority or an officer or employee of the authority.**

**"SECTION 8. Whenever, in any statutory law or resolution of the Legislative Assembly or in any rule, document, record or proceeding authorized by the Legislative Assembly, reference is made to the Oregon Health Insurance Exchange Corporation or an officer or employee of the corporation, the reference is considered to be a reference to the Oregon Health Authority or an officer or employee of the authority.**

**"SECTION 9. The Director of the Oregon Health Authority may take any action before the operative date of section 2 of this 2014 Act that is necessary to enable the director to exercise, on and after the operative date of section 2 of this 2014 Act, the duties, functions and powers of the director pursuant to section 2 of this 2014 Act.**

**"SECTION 10. For the purpose of harmonizing and clarifying statutory law, the Legislative Counsel may substitute for words designating the 'Oregon Health Insurance Exchange Corporation' or its officers, wherever they occur in statutory law, words designating the 'Oregon Health Authority' or its officers and may substitute for words designating the 'executive director of the corporation,' wherever they occur in statutory law, words designating the 'Director of the Oregon Health Authority.**".

In line 20, delete "2" and insert "11".

On page 2, line 15, delete "3" and insert "12".

Delete lines 31 through 45.

On page 3, delete lines 1 through 30.

In line 31, delete "5" and insert "13".

On page 6, after line 25, insert:

**"SECTION 14.** ORS 243.129 is amended to read:

"243.129. (1) The governing body of a local government may elect to participate in a benefit plan offered by the Public Employees' Benefit Board.

"(2) The decision of the governing body of a local government to participate in a benefit plan offered by the board is in the discretion of the governing body of the local government and is a permissive subject of collective bargaining.

"(3) If the governing body of a local government elects to offer a benefit plan through the board, the governing body may elect one time only to provide alternative group health and welfare insurance benefit plans to eligible employees if:

"(a) The alternative benefit plan is offered through the [*health insurance exchange under ORS 741.310 (1)(b)*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041**; and

"(b) The participation of the local government is not precluded under federal law on or after January 1, 2017.

**"SECTION 15.** ORS 243.142 is amended to read:

"243.142. The Oregon Health [*Insurance Exchange Corporation*] **Authority** shall apply for a waiver of federal law or any formal permission from the appropriate federal agency or agencies that is necessary to allow districts and eligible employees of districts to obtain health benefit plans through the [*health*] **federal** insurance exchange in accordance with ORS 243.886.

**"SECTION 16.** ORS 243.867 is amended to read:

"243.867. (1) The governing body of a local government may elect to par-

ticipate in a benefit plan offered by the Oregon Educators Benefit Board.

"(2) The decision of the governing body of a local government to participate in a benefit plan offered by the board is in the discretion of the governing body of the local government and is a permissive subject of collective bargaining.

"(3) If the governing body of a local government elects to offer a benefit plan through the board, the governing body may elect one time only to provide alternative group health and welfare insurance benefit plans to eligible employees if:

"(a) The alternative benefit plan is offered through the [*health insurance exchange under ORS 741.310 (1)(b)*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041**; and

"(b) The participation of the local government is not precluded under federal law on or after January 1, 2017.

**"SECTION 17.** ORS 243.886, as amended by section 13, chapter 38, Oregon Laws 2012, and section 2, chapter 780, Oregon Laws 2013, is amended to read:

"243.886. (1) Except as provided in subsections (2), (3) and (4) of this section, a district may not provide or contract for a benefit plan and eligible employees of districts may not participate in a benefit plan unless the benefit plan:

"(a) Is provided and administered by the Oregon Educators Benefit Board under ORS 243.860 to 243.886; or

"(b) Is offered through the [*health insurance exchange under ORS 741.310 (1)(c)*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041**.

"(2)(a) Except for community college districts, a district that was self-insured before January 1, 2007, or a district that had an independent health insurance trust established and functioning before January 1, 2007, may

provide or contract for benefit plans other than benefit plans provided and administered by the board if the premiums for the benefit plans provided or contracted for by the district are equal to or less than the premiums for comparable benefit plans provided and administered by the board.

"(b) A community college district may provide or contract for benefit plans other than benefit plans provided and administered by the board.

"(c) In accordance with procedures adopted by the board to extend benefit plan coverage under ORS 243.864 to 243.874 to eligible employees of a self-insured district, a district with an independent health insurance trust or a community college district, these districts may choose to offer benefit plans that are provided and administered by the board. Once employees of a district participate in benefit plans provided and administered by the board, the district may not thereafter provide or contract for benefit plans other than those provided and administered by the board.

"(3)(a) A district, other than a district claiming the exception in subsection (2)(a) of this section, that has not offered benefit plans provided and administered by the board before June 23, 2009, may provide or contract for benefit plans other than benefit plans provided and administered by the board if the premiums for the benefit plans provided or contracted for by the district are equal to or less than the premiums for comparable benefit plans provided and administered by the board. Once employees of a district or an employee group within a district participates in benefit plans provided and administered by the board, the district may not thereafter provide or contract for benefit plans for those employees or employee groups other than those provided and administered by the board.

"(b) If requested by the district or a labor organization representing eligible employees of the district, the board shall perform an actuarial analysis of the district.

"(c) As used in this subsection, 'district' does not include a community college district.

"(4) Nothing in ORS 243.860 to 243.886 may be construed to expand or contract collective bargaining rights or collective bargaining obligations.

**"SECTION 18.** ORS 291.229 is amended to read:

"291.229. (1) As part of the development of the legislatively adopted budget in each odd-numbered year regular session of the Legislative Assembly, the Oregon Department of Administrative Services shall make a report to the Joint Committee on Ways and Means on the actions taken by state agencies during the previous biennium to attain a ratio of at least 11 non-supervisory employees to every supervisory employee, as defined in ORS 243.650.

"(2) As used in this section:

"(a) 'State agency' means all state officers, boards, commissions, departments, institutions, branches, agencies, divisions and other entities, without regard to the designation given to those entities, that are within the executive branch of government as described in Article III, section 1, of the Oregon Constitution.

"(b) 'State agency' does not include:

"(A) The legislative department as defined in ORS 174.114;

"(B) The judicial department as defined in ORS 174.113;

"(C) The Public Defense Services Commission;

"(D) The Secretary of State and the State Treasurer in the performance of the duties of their constitutional offices;

"(E) Semi-independent state agencies listed in ORS 182.454;

"(F) The Oregon Tourism Commission;

"(G) The Oregon Film and Video Office;

"(H) The Oregon University System;

"(I) The Oregon Health and Science University;

"(J) The Travel Information Council;

"(K) Oregon Corrections Enterprises;

"(L) The Oregon State Lottery Commission;

"(M) The State Accident Insurance Fund Corporation;

"[*(N) The Oregon Health Insurance Exchange Corporation;*]

"[*(O)*] **(N)** The Oregon Utility Notification Center;

"[*(P)*] **(O)** Oregon Community Power;

"[*(Q)*] **(P)** The Citizens' Utility Board;

"[*(R)*] **(Q)** A special government body as defined in ORS 174.117;

"[*(S)*] **(R)** Any other public corporation created under a statute of this state and specifically designated as a public corporation; and

"[*(T)*] **(S)** Any other semi-independent state agency denominated by statute as a semi-independent state agency.

**"SECTION 19.** ORS 291.231 is amended to read:

"291.231. (1) Notwithstanding ORS 291.229, a state agency that employs more than 100 employees and has not, by April 11, 2012, attained a ratio of at least 11 to 1 of employees of the state agency who are not supervisory employees to supervisory employees:

"(a) May not fill the position of a supervisory employee until the agency has increased the agency's ratio of employees to supervisory employees so that the ratio is at least one additional employee to supervisory employees; and

"(b) Shall, not later than October 31, 2012, lay off or reclassify the number of supervisory employees necessary to attain the increase in the ratio specified in paragraph (a) of this subsection if the increase in that ratio is not attained under paragraph (a) of this subsection or through attrition.

"(2) Notwithstanding ORS 291.229, a state agency that employs more than 100 employees and has complied with the requirements of subsection (1) of this section, but has not attained a ratio of at least 11 to 1 of employees of the state agency who are not supervisory employees to supervisory employees:

"(a) May not fill the position of a supervisory employee until the agency has increased the agency's ratio of employees to supervisory employees by

at least one additional employee; and

"(b) Not later than October 31 of each subsequent year, shall lay off or reclassify the number of supervisory employees necessary to increase the agency's ratio of employees to supervisory employees so that the ratio is at least one additional employee to supervisory employees.

"(3) Layoffs or reclassifications required under this section must be made in accordance with the terms of any applicable collective bargaining agreement. A supervisory employee who is reclassified into a classified position pursuant to this section shall be compensated in the salary range for the classified position unless otherwise provided by an applicable collective bargaining agreement.

"(4) Upon application from a state agency, the Director of the Oregon Department of Administrative Services may grant a state agency an exception from the requirements of subsections (1) to (3) of this section. The director may grant an exception under this section that:

"(a) Applies to a particular position if the director determines the exception is necessary to allow the state agency to maintain public or state agency employee safety;

"(b) Applies to a division, unit, office, branch or other smaller part of the state agency if the director determines the exception is necessary to allow the state agency to maintain public or state agency employee safety or because of the geographic location of the division, unit, office, branch or other smaller part of the state agency; or

"(c) The director determines is warranted because the state agency has supervisory employees exercising authority over personnel who are not employees of the state agency, the state agency has a significant number of part-time or seasonal employees or the state agency has another unique personnel need.

"(5) Not later than five business days before the director proposes to grant an exception under this section, the director shall notify each collec-

tive bargaining agent of the public or state agency employees in the appropriate bargaining unit for the state agency requesting an exception.

"(6) The department shall report all exceptions granted under this subsection to the Joint Committee on Ways and Means, the Joint Interim Committee on Ways and Means or the Emergency Board.

"(7) As used in this section:

"(a)(A) 'State agency' means all state officers, boards, commissions, departments, institutions, branches, agencies, divisions and other entities, without regard to the designation given to those entities, that are within the executive branch of government as described in Article III, section 1, of the Oregon Constitution.

"(B) 'State agency' does not include:

"(i) The legislative department as defined in ORS 174.114;

"(ii) The judicial department as defined in ORS 174.113;

"(iii) The Public Defense Services Commission;

"(iv) The Secretary of State and the State Treasurer in the performance of the duties of their constitutional offices;

"(v) Semi-independent state agencies listed in ORS 182.454;

"(vi) The Oregon Tourism Commission;

"(vii) The Oregon Film and Video Office;

"(viii) The Oregon University System;

"(ix) The Oregon Health and Science University;

"(x) The Travel Information Council;

"(xi) Oregon Corrections Enterprises;

"(xii) The Oregon State Lottery Commission;

"(xiii) The State Accident Insurance Fund Corporation;

"[*(xiv) The Oregon Health Insurance Exchange Corporation;*]

"[*(xv)*] **(xiv)** The Oregon Utility Notification Center;

"[*(xvi)*] **(xv)** Oregon Community Power;

"[*(xvii)*] **(xvi)** The Citizens' Utility Board;

"[*(xviii)*] **(xvii)** A special government body as defined in ORS 174.117;

"[*(xix)*] **(xviii)** Any other public corporation created under a statute of this state and specifically designated as a public corporation; and

"[*(xx)*] **(xix)** Any other semi-independent state agency denominated by statute as a semi-independent state agency.

"(b) 'Supervisory employee' has the meaning given that term in ORS 243.650.

**"SECTION 20.** ORS 351.094 is amended to read:

"351.094. (1)(a) The State Board of Higher Education shall provide group insurance to employees of the Oregon University System through the Public Employees' Benefit Board or may elect to provide an alternative group health and welfare insurance benefit plan to employees of the Oregon University System on or after October 1, 2016, if the benefit plan is offered through the [*health insurance exchange under ORS 741.310*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041**, unless their participation is precluded by federal law.

"(b) The governing board of each university with a governing board listed in ORS 352.054 shall provide group insurance to employees of the university through the Public Employees' Benefit Board or may elect to provide an alternative group health and welfare insurance benefit plan to employees of the university on or after October 1, 2016, if the benefit plan is offered through the [*health insurance exchange under ORS 741.310*] **federal insurance exchange described in paragraph (a) of this subsection**, unless their participation is precluded by federal law.

"(2) For the purposes of ORS 243.555 to 243.575, if the State Board of Higher Education or the governing board of a public university with a governing board listed in ORS 352.054 chooses not to participate in the benefit plans offered through the Public Employees' Benefit Board, the State Board of Higher Education or governing board may have the authority granted to

the Public Employees' Benefit Board under ORS 243.555 to 243.575 for the administration of an appropriate expense reimbursement plan.

"(3)(a) The State Board of Higher Education shall offer one or more deferred compensation plans to employees of the Oregon University System. The Oregon University System shall, at the discretion of the board, choose whether to offer its employees the state deferred compensation plan established under ORS 243.401 to 243.507 or another deferred compensation plan that the board elects to make available to the employees of the Oregon University System.

"(b) The governing board of each public university with a governing board listed in ORS 352.054 shall offer one or more deferred compensation plans to employees of the university. The governing board shall choose whether to offer its employees the state deferred compensation plan established under ORS 243.401 to 243.507 or another deferred compensation plan that the governing board elects to make available to the employees of the university.

**"SECTION 21.** ORS 411.400 is amended to read:

"411.400. (1) An application for any category of aid shall also constitute an application for medical assistance.

"(2) [*Except as provided in subsection (6) of this section,*] The Department of Human Services and the Oregon Health Authority shall accept an application for medical assistance and any required verification of eligibility from the applicant, an adult who is in the applicant's household or family, an authorized representative of the applicant or, if the applicant is a minor or incapacitated, someone acting on behalf of the applicant:

"(a) Over the Internet;

"(b) By telephone;

"(c) By mail;

"(d) In person; and

"(e) Through other commonly available electronic means.

"(3) The department and the authority may require an applicant or person

acting on behalf of an applicant to provide only the information necessary for the purpose of making an eligibility determination or for a purpose directly connected to the administration of medical assistance or the [*health*] **federal** insurance exchange.

"(4) The department and the authority shall provide application and recertification assistance to individuals with disabilities, individuals with limited English proficiency, individuals facing physical or geographic barriers and individuals seeking help with the application for medical assistance or recertification of eligibility for medical assistance:

"(a) Over the Internet;

"(b) By telephone; and

"(c) In person.

"(5)(a) The department and the authority shall promptly transfer information received under this section to the [*Oregon Health Insurance Exchange Corporation*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041** as necessary for the [*corporation*] **exchange** to determine eligibility for the exchange, premium tax credits or cost-sharing reductions.

"(b) The department shall promptly transfer information received under this section to the authority for individuals who are eligible for medical assistance because they qualify for public assistance.

"[*(6) The department and the authority shall accept from the corporation an application and any verification that was submitted to the corporation by an applicant or on behalf of an applicant for the determination of eligibility for medical assistance.*]

**"SECTION 22.** ORS 411.402 is amended to read:

"411.402. (1) The Department of Human Services and the Oregon Health Authority shall adopt by rule, consistent with federal requirements, the procedures for verifying eligibility for medical assistance, including but not limited to all of the following:

"(a) The department and the authority shall access all relevant state and federal electronic databases for any eligibility information available through the databases.

"(b) The department and the authority shall verify the following factors through self-attestation:

"(A) Pregnancy;

"(B) Date of birth;

"(C) Household composition; and

"(D) Residency.

"(c) The department and the authority may not use self-attestation to verify citizenship and immigration status.

"(d) The department and the authority may require the applicant to provide verification in addition to the verification specified in this subsection only if the department and the authority are unable to obtain the information electronically or if the information obtained electronically is not reasonably compatible with information provided by or on behalf of the applicant.

"(e) The department and the authority shall use methods of administration that are in the best interests of applicants and recipients and that are necessary for the proper and efficient operation of the medical assistance program.

"(2) Information obtained by the department or the authority under this section may be exchanged with [*the health insurance exchange and with*] other state or federal agencies for the purpose of:

"(a) Verifying eligibility for medical assistance, participation in the [*exchange*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041** or other health benefit programs;

"(b) Establishing the amount of any tax credit due to the person, cost-sharing reduction or premium assistance;

"(c) Improving the provision of services; and

"(d) Administering health benefit programs.

**"SECTION 23.** ORS 411.406 is amended to read:

"411.406. (1) A medical assistance recipient shall immediately notify the Department of Human Services or the Oregon Health Authority, if required, of the receipt or possession of property or income or other change in circumstances that directly affects the eligibility of the recipient to receive medical assistance, or that directly affects the amount of medical assistance for which the recipient is eligible. Failure to give the notice shall entitle the department or the authority to recover from the recipient the amount of assistance improperly disbursed by reason thereof.

"(2)(a) The department or the authority shall redetermine the eligibility of a medical assistance recipient at intervals specified by federal law.

"(b) The department and the authority shall redetermine eligibility under this subsection on the basis of information available to the department and the authority and may not require the recipient to provide information if the department or the authority is able to determine eligibility based on information in the recipient's record or through other information that is available to the department or the authority.

"(3) Notwithstanding subsection (2) of this section, if the department or the authority receives information about a change in a medical assistance recipient's circumstances that may affect eligibility for medical assistance, the department or the authority shall promptly redetermine eligibility.

"(4) If the department or the authority determines that a medical assistance recipient no longer qualifies for the medical assistance program in which the recipient is enrolled, the department or the authority must determine eligibility for other medical assistance programs, potential eligibility for the [*health insurance exchange*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041**, premium tax credits and cost-sharing

reductions before terminating the recipient's medical assistance. If the recipient appears to qualify for the exchange, premium tax credits or cost-sharing reductions, the department or the authority shall promptly transfer the recipient's record to the **federal insurance** exchange to process those benefits.

**"SECTION 24.** ORS 413.011 is amended to read:

"413.011. (1) The duties of the Oregon Health Policy Board are to:

"(a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS 413.032 and all of the authority's departmental divisions.

"[*(b) Develop and submit a plan to the Legislative Assembly by December 31, 2010, to provide and fund access to affordable, quality health care for all Oregonians by 2015.*]

"[*(c)*] **(b)** Develop a program to provide health insurance premium assistance to all low and moderate income individuals who are legal residents of Oregon.

"[*(d)*] **(c)** Establish and continuously refine uniform, statewide health care quality standards for use by all purchasers of health care, third-party payers and health care providers as quality performance benchmarks.

"[*(e)*] **(d)** Establish evidence-based clinical standards and practice guidelines that may be used by providers.

"[*(f)*] **(e)** Approve and monitor community-centered health initiatives described in ORS 413.032 (1)(h) that are consistent with public health goals, strategies, programs and performance standards adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and shall regularly report to the Legislative Assembly on the accomplishments and needed changes to the initiatives.

"[*(g)*] **(f)** Establish cost containment mechanisms to reduce health care costs.

"[*(h)*] **(g)** Ensure that Oregon's health care workforce is sufficient in

numbers and training to meet the demand that will be created by the expansion in health coverage, health care system transformations, an increasingly diverse population and an aging workforce.

"[*(i)*] **(h)** Work with the Oregon congressional delegation to advance the adoption of changes in federal law or policy to promote Oregon's comprehensive health reform plan.

"[*(j) Establish a health benefit package in accordance with ORS 741.340 to be used as the baseline for all health benefit plans offered through the Oregon health insurance exchange.*]

"[*(k)*] **(i)** Investigate and report annually to the Legislative Assembly on the feasibility and advisability of future changes to the health insurance market in Oregon, including but not limited to the following:

"(A) A requirement for every resident to have health insurance coverage.

"(B) A payroll tax as a means to encourage employers to continue providing health insurance to their employees.

"(C) The implementation of a system of interoperable electronic health records utilized by all health care providers in this state.

"[*(L)*] **(j)** Meet cost-containment goals by structuring reimbursement rates to reward comprehensive management of diseases, quality outcomes and the efficient use of resources by promoting cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations.

"[*(m)*] **(k)** Oversee the expenditure of moneys from the Health Care Workforce Strategic Fund to support grants to primary care providers and rural health practitioners, to increase the number of primary care educators and to support efforts to create and develop career ladder opportunities.

"[*(n)*] **(L)** Work with the Public Health Benefit Purchasers Committee, administrators of the medical assistance program and the Department of Corrections to identify uniform contracting standards for health benefit

plans that achieve maximum quality and cost outcomes and align the contracting standards for all state programs to the greatest extent practicable.

"(2) The Oregon Health Policy Board is authorized to:

"(a) Subject to the approval of the Governor, organize and reorganize the authority as the board considers necessary to properly conduct the work of the authority.

"(b) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the board's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

"(3) If the board or the authority is unable to perform, in whole or in part, any of the duties described in ORS 413.006 to 413.042 [*and 741.340*] without federal approval, the authority is authorized to request, in accordance with ORS 413.072, waivers or other approval necessary to perform those duties. The authority shall implement any portions of those duties not requiring legislative authority or federal approval, to the extent practicable.

"(4) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042 [*and 741.340*] and by other statutes.

"(5) The board shall consult with the Department of Consumer and Business Services in completing the tasks set forth in subsection [*(1)(j) and (k)(A)*] **(1)(i)(A)** of this section.

**"SECTION 25.** ORS 413.017 is amended to read:

"413.017. (1) The Oregon Health Policy Board shall establish the committees described in subsections (2) and (3) of this section.

"(2)(a) The Public Health Benefit Purchasers Committee shall include individuals who purchase health care for the following:

"(A) The Public Employees' Benefit Board.

"(B) The Oregon Educators Benefit Board.

"(C) Trustees of the Public Employees Retirement System.

"(D) A city government.

"(E) A county government.

"(F) A special district.

"(G) Any private nonprofit organization that receives the majority of its funding from the state and requests to participate on the committee.

"(b) The Public Health Benefit Purchasers Committee shall:

"(A) Identify and make specific recommendations to achieve uniformity across all public health benefit plan designs based on the best available clinical evidence, recognized best practices for health promotion and disease management, demonstrated cost-effectiveness and shared demographics among the enrollees within the pools covered by the benefit plans.

"(B) Develop an action plan for ongoing collaboration to implement the benefit design alignment described in subparagraph (A) of this paragraph and shall leverage purchasing to achieve benefit uniformity if practicable.

"(C) Continuously review and report to the Oregon Health Policy Board on the committee's progress in aligning benefits while minimizing the cost shift to individual purchasers of insurance without shifting costs to the private sector or the [*Oregon Health Insurance Exchange*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041**.

"(c) The Oregon Health Policy Board shall work with the Public Health Benefit Purchasers Committee to identify uniform provisions for state and local public contracts for health benefit plans that achieve maximum quality and cost outcomes. The board shall collaborate with the committee to develop steps to implement joint contract provisions. The committee shall identify a schedule for the implementation of contract changes. The process for implementation of joint contract provisions must include a review process

to protect against unintended cost shifts to enrollees or agencies.

"[*(d) Proposals and plans developed in accordance with this subsection shall be completed by October 1, 2010, and shall be submitted to the Oregon Health Policy Board for its approval and possible referral to the Legislative Assembly no later than December 31, 2010.*]

"(3)(a) The Health Care Workforce Committee shall include individuals who have the collective expertise, knowledge and experience in a broad range of health professions, health care education and health care workforce development initiatives.

"(b) The Health Care Workforce Committee shall coordinate efforts to recruit and educate health care professionals and retain a quality workforce to meet the demand that will be created by the expansion in health care coverage, system transformations and an increasingly diverse population.

"(c) The Health Care Workforce Committee shall conduct an inventory of all grants and other state resources available for addressing the need to expand the health care workforce to meet the needs of Oregonians for health care.

"(4) Members of the committees described in subsections (2) and (3) of this section who are not members of the Oregon Health Policy Board are not entitled to compensation but shall be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495.

**"SECTION 26.** ORS 413.032 is amended to read:

"413.032. (1) The Oregon Health Authority is established. The authority shall:

"(a) Carry out policies adopted by the Oregon Health Policy Board;

"(b) Administer the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.620;

"(c) Administer the Oregon Prescription Drug Program;

"(d) Develop the policies for and the provision of publicly funded medical care and medical assistance in this state;

"(e) Develop the policies for and the provision of mental health treatment and treatment of addictions;

"(f) Assess, promote and protect the health of the public as specified by state and federal law;

"(g) Provide regular reports to the board with respect to the performance of health services contractors serving recipients of medical assistance, including reports of trends in health services and enrollee satisfaction;

"(h) Guide and support, with the authorization of the board, community-centered health initiatives designed to address critical risk factors, especially those that contribute to chronic disease;

"(i) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the Social Security Act and administer medical assistance under ORS chapter 414;

"(j) In consultation with the Director of the Department of Consumer and Business Services, periodically review and recommend standards and methodologies to the Legislative Assembly for:

"(A) Review of administrative expenses of health insurers;

"(B) Approval of rates; and

"(C) Enforcement of rating rules adopted by the Department of Consumer and Business Services;

"(k) Structure reimbursement rates for providers that serve recipients of medical assistance to reward comprehensive management of diseases, quality outcomes and the efficient use of resources and to promote cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations;

"(L) Guide and support community three-share agreements in which an employer, state or local government and an individual all contribute a por-

tion of a premium for a community-centered health initiative or for insurance coverage;

"(m) Develop, in consultation with the Department of Consumer and Business Services, one or more products designed to provide more affordable options for the small group market; and

"(n) Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4).

"(2) The Oregon Health Authority is authorized to:

"(a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate health care reform in Oregon and to provide comparative cost and quality information to consumers, providers and purchasers of health care about Oregon's health care systems and health plan networks in order to provide comparative information to consumers.

"(b) Develop uniform contracting standards for the purchase of health care, including the following:

"(A) Uniform quality standards and performance measures;

"(B) Evidence-based guidelines for major chronic disease management and health care services with unexplained variations in frequency or cost;

"(C) Evidence-based effectiveness guidelines for select new technologies and medical equipment; and

"(D) A statewide drug formulary that may be used by publicly funded health benefit plans.

"(3) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Authority by ORS 413.006 to 413.042 [*and 741.340*] or by other statutes.

**"SECTION 27.** ORS 413.037 is amended to read:

"413.037. (1) The Director of the Oregon Health Authority, each deputy director and authorized representatives of the director may administer oaths, take depositions and issue subpoenas to compel the attendance of witnesses

and the production of documents or other written information necessary to carry out the provisions of ORS 413.006 to 413.042 [*and 741.340*].

"(2) If any person fails to comply with a subpoena issued under this section or refuses to testify on matters on which the person lawfully may be interrogated, the director, deputy director or authorized representative may follow the procedure set out in ORS 183.440 to compel obedience.

**"SECTION 28.** ORS 413.085 is amended to read:

"413.085. The Director of Human Services[*, the executive director of the Oregon Health Insurance Exchange Corporation*] and the Director of the Oregon Health Authority may delegate to each other by interagency agreement any duties, functions or powers granted to the Department of Human Services[*, the corporation*] or the Oregon Health Authority by law, as the directors deem necessary for the efficient and effective operation of the respective functions of the department[*, the corporation*] and the authority.

**"SECTION 29.** ORS 414.115 is amended to read:

"414.115. (1) In lieu of providing one or more of the health care and services available under medical assistance by direct payments to providers thereof and in lieu of providing such health care and services made available pursuant to ORS 414.065, the Oregon Health Authority may use available medical assistance funds to purchase and pay premiums on policies of insurance, or enter into and pay the expenses on health care service contracts, or medical or hospital service contracts that provide one or more of the health care and services available under medical assistance. Notwithstanding other specific provisions, the use of available medical assistance funds to purchase health care and services may provide the following insurance or contract options:

"(a) Differing services or levels of service among groups of eligibles as defined by rules of the authority; and

"(b) Services and reimbursement for these services may vary among contracts and need not be uniform.

"(2) The policy of insurance or the contract by its terms, or the insurer or contractor by written acknowledgment to the authority must guarantee:

"(a) To provide health care and services of the type, within the extent and according to standards prescribed under ORS 414.065;

"(b) To pay providers of health care and services the amount due, based on the number of days of care and the fees, charges and costs established under ORS 414.065, except as to medical or hospital service contracts which employ a method of accounting or payment on other than a fee-for-service basis;

"(c) To provide health care and services under policies of insurance or contracts in compliance with all laws, rules and regulations applicable thereto; and

"(d) To provide such statistical data, records and reports relating to the provision, administration and costs of providing health care and services to the authority as may be required by the authority for its records, reports and audits.

"(3) The authority may purchase insurance under this section through the [*health insurance exchange*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041**.

**"SECTION 30.** ORS 414.826 is amended to read:

"414.826. (1) As used in this section:

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

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

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

"(2) The Oregon Health Authority shall administer a private health option to expand access to private health insurance for Oregon's children.

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

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

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

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

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

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

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

"(5) The amount of premium assistance provided under this section shall be:

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

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

"(6) Premium assistance may be available under this section to a child described in subsection (5)(b) of this section for a health benefit plan pur-

chased through the [*Oregon health insurance exchange*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041**.

**"SECTION 31.** ORS 743.730 is amended to read:

"743.730. For purposes of ORS 743.730 to 743.773:

"(1) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743.736 based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer health benefit plans.

"(2) 'Affiliate' of, or person 'affiliated' with, a specified person means any carrier who, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with a specified person. For purposes of this definition, 'control' has the meaning given that term in ORS 732.548.

"(3) 'Affiliation period' means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

"(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee;

"(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

"(c) During which no premium shall be charged to the enrollee or late enrollee; and

"(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under the plan.

"(4) 'Bona fide association' means an association that:

"(a) Has been in active existence for at least five years;

"(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

"(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

"(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

"(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

"(f) Has a constitution and bylaws; and

"(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

"(5) 'Carrier' means any person who provides health benefit plans in this state, including:

"(a) A licensed insurance company;

"(b) A health care service contractor;

"(c) A health maintenance organization;

"(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

"(A) Is subject to ORS 750.301 to 750.341; or

"(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

"(e) Any other person or corporation responsible for the payment of benefits or provision of services.

"(6) 'Catastrophic plan' means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the [*Oregon health insurance*] exchange.

"(7) 'Creditable coverage' means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the enrollee obtains new coverage.

"(8) 'Dependent' means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

"(9) 'Eligible employee' means an employee who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. 'Eligible employee' does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the employer for fewer than 90 days are not eligible employees unless the employer so allows.

"(10) 'Employee' means any individual employed by an employer.

"(11) 'Enrollee' means an employee, dependent of the employee or an individual otherwise eligible for a group or individual health benefit plan who has enrolled for coverage under the terms of the plan.

"(12) 'Exchange' means the [*health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041**.

"(13) 'Exclusion period' means a period during which specified treatments or services are excluded from coverage.

"(14) 'Financial impairment' means that a carrier is not insolvent and is:

"(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

"(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"(15)(a) 'Geographic average rate' means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a

carrier in a geographic area established by the director for the carrier's:

"(A) Group health benefit plans offered to small employers; or

"(B) Individual health benefit plans.

"(b) 'Geographic average rate' does not include premium differences that are due to differences in benefit design, age, tobacco use or family composition.

"(16) 'Grandfathered health plan' has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

"(17) 'Group eligibility waiting period' means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

"(18)(a) 'Health benefit plan' means any:

"(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

"(B) Health care service contractor or health maintenance organization subscriber contract; or

"(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

"(b) 'Health benefit plan' does not include:

"(A) Coverage for accident only, specific disease or condition only, credit or disability income;

"(B) Coverage of Medicare services pursuant to contracts with the federal government;

"(C) Medicare supplement insurance policies;

"(D) Coverage of TRICARE services pursuant to contracts with the federal government;

"(E) Benefits delivered through a flexible spending arrangement estab-

lished pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

"(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

"(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

"(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

"(I) Dental only coverage;

"(J) Vision only coverage;

"(K) Stop-loss coverage that meets the requirements of ORS 742.065;

"(L) Coverage issued as a supplement to liability insurance;

"(M) Insurance arising out of a workers' compensation or similar law;

"(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

"(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

"(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

"(19) 'Individual coverage waiting period' means a period in an individual health benefit plan during which no premiums may be collected and health benefit plan coverage issued is not effective.

"(20) 'Individual health benefit plan' means a health benefit plan:

"(a) That is issued to an individual policyholder; or

"(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

"(21) 'Initial enrollment period' means a period of at least 30 days following commencement of the first eligibility period for an individual.

"(22) 'Late enrollee' means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

"(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer and Business Services;

"(b) The individual applies for coverage during an open enrollment period;

"(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

"(d) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

"(e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

"(23) 'Minimal essential coverage' has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

"(24) 'Multiple employer welfare arrangement' means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject

to ORS 750.301 to 750.341.

"(25) 'Preexisting condition exclusion' means:

"(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

"(b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of this paragraph pregnancy and genetic information do not constitute preexisting conditions.

"(26) 'Premium' includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

"(27) 'Rating period' means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

"(28) 'Representative' does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

"(29)(a) 'Small employer' means an employer that employed an average of at least one but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least one eligible employee on the first day of the plan year.

"(b) Any person that is treated as a single employer under section 414 (b), (c), (m) or (o) of the Internal Revenue Code of 1986 shall be treated as one

employer for purposes of this subsection.

"(c) The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

**"SECTION 32.** ORS 743.730, as amended by section 59, chapter 681, Oregon Laws 2013, is amended to read:

"743.730. For purposes of ORS 743.730 to 743.773:

"(1) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743.736 based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer health benefit plans.

"(2) 'Affiliate' of, or person 'affiliated' with, a specified person means any carrier who, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with a specified person. For purposes of this definition, 'control' has the meaning given that term in ORS 732.548.

"(3) 'Affiliation period' means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

"(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee;

"(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

"(c) During which no premium shall be charged to the enrollee or late enrollee; and

"(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under

the plan.

"(4) 'Bona fide association' means an association that:

"(a) Has been in active existence for at least five years;

"(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

"(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

"(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

"(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

"(f) Has a constitution and bylaws; and

"(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

"(5) 'Carrier' means any person who provides health benefit plans in this state, including:

"(a) A licensed insurance company;

"(b) A health care service contractor;

"(c) A health maintenance organization;

"(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

"(A) Is subject to ORS 750.301 to 750.341; or

"(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

"(e) Any other person or corporation responsible for the payment of benefits or provision of services.

"(6) 'Catastrophic plan' means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the [*Oregon health insurance*] exchange.

"(7) 'Creditable coverage' means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the enrollee obtains new coverage.

"(8) 'Dependent' means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

"(9) 'Eligible employee' means an employee who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. 'Eligible employee' does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the employer for fewer than 90 days are not eligible employees unless the employer so allows.

"(10) 'Employee' means any individual employed by an employer.

"(11) 'Enrollee' means an employee, dependent of the employee or an individual otherwise eligible for a group or individual health benefit plan who has enrolled for coverage under the terms of the plan.

"(12) 'Exchange' means the [*health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041**.

"(13) 'Exclusion period' means a period during which specified treatments or services are excluded from coverage.

"(14) 'Financial impairment' means that a carrier is not insolvent and is:

"(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

"(b) Placed under an order of rehabilitation or conservation by a court

of competent jurisdiction.

"(15)(a) 'Geographic average rate' means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

"(A) Group health benefit plans offered to small employers; or

"(B) Individual health benefit plans.

"(b) 'Geographic average rate' does not include premium differences that are due to differences in benefit design, age, tobacco use or family composition.

"(16) 'Grandfathered health plan' has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

"(17) 'Group eligibility waiting period' means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

"(18)(a) 'Health benefit plan' means any:

"(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

"(B) Health care service contractor or health maintenance organization subscriber contract; or

"(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

"(b) 'Health benefit plan' does not include:

"(A) Coverage for accident only, specific disease or condition only, credit or disability income;

"(B) Coverage of Medicare services pursuant to contracts with the federal government;

"(C) Medicare supplement insurance policies;

"(D) Coverage of TRICARE services pursuant to contracts with the federal government;

"(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

"(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

"(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

"(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

"(I) Dental only coverage;

"(J) Vision only coverage;

"(K) Stop-loss coverage that meets the requirements of ORS 742.065;

"(L) Coverage issued as a supplement to liability insurance;

"(M) Insurance arising out of a workers' compensation or similar law;

"(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

"(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

"(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

"(19) 'Individual coverage waiting period' means a period in an individual

health benefit plan during which no premiums may be collected and health benefit plan coverage issued is not effective.

"(20) 'Individual health benefit plan' means a health benefit plan:

"(a) That is issued to an individual policyholder; or

"(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

"(21) 'Initial enrollment period' means a period of at least 30 days following commencement of the first eligibility period for an individual.

"(22) 'Late enrollee' means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

"(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer and Business Services;

"(b) The individual applies for coverage during an open enrollment period;

"(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

"(d) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

"(e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

"(23) 'Minimal essential coverage' has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

"(24) 'Multiple employer welfare arrangement' means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

"(25) 'Preexisting condition exclusion' means:

"(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

"(b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of this paragraph pregnancy and genetic information do not constitute preexisting conditions.

"(26) 'Premium' includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

"(27) 'Rating period' means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

"(28) 'Representative' does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

"(29)(a) 'Small employer' means an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least one eligible employee on the first day of the

plan year.

"(b) Any person that is treated as a single employer under section 414 (b), (c), (m) or (o) of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this subsection.

"(c) The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

**"SECTION 33.** ORS 743.733 is amended to read:

"743.733. (1) If an affiliated group of employers is treated as a single employer under section 414 (b), (c), (m) or (o) of the Internal Revenue Code of 1986, a carrier may issue a single group health benefit plan to the affiliated group on the basis of the number of employees in the affiliated group if the group requests such coverage.

"(2) Subsequent to the issuance of a health benefit plan to a small employer, other than a plan issued through the [*Oregon health insurance*] exchange, a carrier shall determine annually the number of employees of the employer for purposes of determining the employer's ongoing eligibility as a small employer.

"(3)(a) ORS 743.733 to 743.737 shall continue to apply to a health benefit plan issued outside of the exchange to a small employer until the plan anniversary date following the date the employer no longer meets the definition of a small employer.

"(b) ORS 743.733 to 743.737 shall continue to apply to an employer that receives coverage through the exchange until the employer no longer receives coverage through the exchange and is no longer a small employer.

**"SECTION 34.** ORS 743.822 is amended to read:

"743.822. (1) In each individual or small group market, in which a carrier offers a health benefit plan through or outside of the [*Oregon health insurance exchange*] **federal insurance exchange established by the United**

**States Department of Health and Human Services in accordance with 42 U.S.C. 18041**, the carrier must offer to residents of this state a bronze and a silver plan approved by the [*Department of Consumer and Business Services as meeting the requirements of subsection (2) of this section*] **United States Department of Health and Human Services**.

"[*(2) The department shall prescribe by rule the form, level of coverage and benefit design for the bronze and silver plans that must be offered under subsection (1) of this section.*]

"[*(3)*] **(2)** As used in this section, 'health benefit plan' has the meaning given that term in ORS 743.730.

**"SECTION 35.** ORS 743.826 is amended to read:

"743.826. A carrier may offer a catastrophic plan only through the [*exchange*] **federal insurance exchange established by the United States Department of Health and Human Services in accordance with 42 U.S.C. 18041** and only to an individual who:

"(1) Is under 30 years of age at the beginning of the plan year; or

"(2) Is exempt from any [*state or*] federal penalties imposed for failing to maintain minimal essential coverage during the plan year.

**"SECTION 36.** Section 11, chapter 8, Oregon Laws 2012, as amended by section 2, chapter 368, Oregon Laws 2013, is amended to read:

"**Sec. 11.** In each calendar quarter, the Oregon Health Authority shall report to the appropriate committees or interim committees of the Legislative Assembly:

"(1) On the implementation of the Oregon Integrated and Coordinated Care Delivery System;

"(2) On the progress in implementing an arbitration process in accordance with ORS 414.635 (7);

"(3) For the purpose of developing a baseline with which to compare future costs, per member costs for each category of service; **and**

"(4) The administrative costs to the authority in the implementation of

the system and the aggregate financial information reported to the authority by coordinated care organizations, including but not limited to the coordinated care organizations':

"(a) Payments for each category of service as prescribed by the authority; and

"(b) Reserves, projected cash flows and other financial information prescribed by the authority by rule.[*; and*]

"[*(5) On efforts made, in collaboration with the Oregon Health Insurance Exchange Corporation, to coordinate eligibility determination and enrollment processes for qualified health plans and the state medical assistance program.*]

**"SECTION 37.** Section 1, chapter 712, Oregon Laws 2013, is amended to read:

"**Sec. 1.** (1) The Legislative Assembly finds that the best system for the delivery and financing of health care in this state will be the system that:

"(a) Provides universal access to comprehensive care at the appropriate time.

"(b) Ensures transparency and accountability.

"(c) Enhances primary care.

"(d) Allows the choice of health care provider.

"(e) Respects the primacy of the patient-provider relationship.

"(f) Provides for continuous improvement of health care quality and safety.

"(g) Reduces administrative costs.

"(h) Has financing that is sufficient, fair and sustainable.

"(i) Ensures adequate compensation of health care providers.

"(j) Incorporates community-based systems.

"(k) Includes effective cost controls.

"(L) Provides universal access to care even if the person is outside of Oregon.

"(m) Provides seamless birth-to-death access to care.

"(n) Minimizes medical errors.

"(o) Focuses on preventative health care.

"(p) Integrates physical, dental, vision and mental health care.

"(q) Includes long term care.

"(r) Provides equitable access to health care, according to a person's needs.

"(s) Is affordable for individuals, families, businesses and society.

"(2) To the extent practicable using only the funds received under section 2**, chapter 712, Oregon Laws 2013** [*of this 2013 Act*], the Oregon Health Authority shall contract with a third party to conduct a study overseen by the authority to examine at least four options for financing health care delivery in this state, including:

"(a) An option for a publicly financed single-payer model for financing privately delivered health care, that is decoupled from employment and allows commercial insurance coverage only of supplemental health services not paid for under the option.

"(b) An option that allows a person to choose between a publicly funded plan, including a basic health program under 42 U.S.C. 18051, and private insurance coverage and allows for fair and robust competition among public plans and private insurance.

"(c) The current health care financing system in this state, including the:

"(A) Oregon Integrated and Coordinated Health Care Delivery System; **and**

"[*(B) Oregon health insurance exchange; and*]

"[*(C)*] **(B)** Full implementation of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act (P.L. 111-152) and other subsequent amendments.

"(d) An option for a plan that provides essential health benefits, including preventive care and hospital services, and that:

"(A) Allows a person to access the commercial market to purchase coverage that is not covered under the plan;

"(B) Limits the role of the plan to collecting and distributing revenue while preserving private sector delivery options and optimizing consumer choice;

"(C) Offers to Oregonians who earn more than 400 percent of the federal poverty guidelines a deductible plan that could be contributed to by employees and employers;

"(D) Exempts Oregonians who earn no more than 400 percent of the federal poverty guidelines from deductibles;

"(E) Accesses all sources of available federal funding; and

"(F) Identifies program savings that can be achieved by providing health care coverage to all Oregonians, including but not limited to using the program to replace the state medical assistance program and the medical portion of worker's compensation, then applies the savings to finance the plan.

"(3) The researchers conducting the study shall review and consider:

"(a) Previous studies in this state of alternative models of health care financing or delivery.

"(b) Studies of health care financing and delivery systems in other states and countries.

"(c) This state's current health care reform efforts.

"(d) The impact on and interplay with each option of all of the following:

"(A) The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act (P.L. 111-152) and other subsequent amendments;

"(B) The Employee Retirement Income Security Act of 1974; and

"(C) Titles XVIII, XIX and XXI of the Social Security Act.

"(4) The contractor shall prepare a report that summarizes the findings of the study and:

"(a) Analyzes the costs and benefits of requiring copayments and of not

requiring copayments.

"(b) Describes options for health care financing by a government agency, by commercial insurance and by a combination of both government and commercial insurance.

"(c) For each option:

"(A) Evaluates the extent to which the option satisfies the criteria described in subsection (1) of this section;

"(B) Estimates the cost of implementation, including anticipated costs from increased services, more patients, new facilities and savings from efficiencies;

"(C) Assesses the impact of implementation on the existing commercial insurance and publicly funded health care systems;

"(D) Estimates the net fiscal impact of implementation on individuals and businesses including the tax implications;

"(E) Assesses the impact of implementation on the economy of this state; and

"(F) Estimates the potential savings to local governments and government agencies that currently administer health care programs, provide health care premium subsidies or provide funding for health care services.

"(5) The report must include a recommendation for the option for health care delivery and financing that best satisfies the criteria described in subsection (1) of this section and that:

"(a) Maximizes available federal funding; and

"(b) Ensures that health care providers receive adequate compensation for providing health care.

**"SECTION 38. Sections 2 to 10 of this 2014 Act and the amendments to ORS 243.129, 243.142, 243.867, 243.886, 291.229, 291.231, 351.094, 411.400, 411.402, 411.406, 413.011, 413.017, 413.032, 413.037, 413.085, 414.115, 414.826, 743.730, 743.733, 743.822 and 743.826 and section 11, chapter 8, Oregon Laws 2012, section 1, chapter 712, Oregon Laws 2013, by sections 14**

**through 37 of this 2014 Act become operative 30 days after the effective date of this 2014 Act.**

**"SECTION 39. (1) ORS 741.001, 741.002, 741.025, 741.027, 741.029, 741.031, 741.101, 741.105, 741.201, 741.220, 741.222, 741.250, 741.255, 741.300, 741.310, 741.340, 741.381, 741.400, 741.500, 741.510, 741.520 and 741.540 and section 27, chapter 415, Oregon Laws 2011, as amended by section 8, chapter 38, Oregon Laws 2012, section 14, chapter 38, Oregon Laws 2012, and section 4, chapter 368, Oregon Laws 2013, are repealed 30 days after the effective date of this 2014 Act.**

**"(2) ORS 741.390 and 741.900 are repealed January 1, 2015."**.

In line 26, delete "6" and insert "40".

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