

**PROPOSED AMENDMENTS TO  
A-ENGROSSED HOUSE BILL 4110**

1 On page 1 of the printed A-engrossed bill, line 2, before the period insert  
2 “; creating new provisions; amending ORS 238.538, 243.129, 243.135, 243.142,  
3 243.867, 243.886, 291.229, 291.231, 292.430, 351.094, 411.400, 411.402, 411.406,  
4 413.011, 413.017, 413.032, 413.037, 413.085, 414.115, 414.826, 743.730, 743.733,  
5 743.822 and 743.826 and section 11, chapter 8, Oregon Laws 2012, and section  
6 1, chapter 712, Oregon Laws 2013; repealing ORS 741.001, 741.002, 741.025,  
7 741.027, 741.029, 741.031, 741.101, 741.105, 741.201, 741.220, 741.222, 741.250,  
8 741.255, 741.300, 741.310, 741.340, 741.381, 741.390, 741.400, 741.500, 741.510,  
9 741.520, 741.540 and 741.900 and section 27, chapter 415, Oregon Laws 2011,  
10 section 14, chapter 38, Oregon Laws 2012, and section 4, chapter 368, Oregon  
11 Laws 2013; and declaring an emergency”.

12 On page 2, line 16, delete “the effective date of this 2014 Act.” and insert  
13 “January 1, 2015.

14 **“SECTION 4. The Oregon Health Insurance Exchange Corporation**  
15 **board of directors or the executive director of the Oregon Health In-**  
16 **surance Exchange Corporation shall make available on the**  
17 **corporation’s website, and upon request to any person, all of the**  
18 **findings resulting from an independent review, investigation or audit**  
19 **of the development, implementation or quality control of the health**  
20 **insurance exchange if the review, investigation or audit is contracted**  
21 **for or paid for, in whole or in part, by the corporation or by the**  
22 **Oregon Health Authority. The findings shall be made available on the**

1 website no later than 14 days after the receipt of the findings by the  
2 corporation or the authority.

3 **“SECTION 5. The Oregon Health Authority shall request a waiver**  
4 **from the appropriate federal agencies to permit individuals to pur-**  
5 **chase qualified health plans, as defined in 42 U.S.C. 18021, directly from**  
6 **insurers and to qualify for premium tax credits, under section 36B of**  
7 **the Internal Revenue Code, and cost-sharing reductions under 42**  
8 **U.S.C. 18071, if the individual:**

9 **“(1) Is under the age of 65;**

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

11 **“(3) Would not have qualified for medical assistance under 42 U.S.C.**  
12 **1396a as in effect on December 31, 2013; and**

13 **“(4) Would qualify for premium tax credits or cost-sharing re-**  
14 **ductions but for the individual’s purchase of a health plan directly**  
15 **from an insurer.**

16 **“SECTION 6. (1) The Oregon Health Insurance Exchange Corpo-**  
17 **ration is abolished. On the operative date of this section, the tenure**  
18 **of office of the members of the board of directors of the corporation**  
19 **and of the executive director of the corporation ceases.**

20 **“(2) All the duties, functions and powers of the corporation are**  
21 **imposed upon, transferred to and vested in the Oregon Health Au-**  
22 **thority.**

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

25 **“SECTION 7. The Oregon Health Insurance Exchange Corporation**  
26 **shall transfer to the Oregon Health Authority ownership of accounts**  
27 **established under ORS 741.101. The authority shall cease the imposi-**  
28 **tion of charges and fees under ORS 741.105. The authority shall return**  
29 **all moneys received in federal grants to the appropriate federal agency**  
30 **and shall use the nonfederal moneys in the accounts to take all nec-**

1 **essary steps to cease the operation of the Oregon Health Insurance**  
2 **Exchange Corporation and the health insurance exchange.**

3 **“SECTION 8. (1) The executive director of the Oregon Health In-**  
4 **surance Exchange Corporation shall:**

5 **“(a) Deliver to the Oregon Health Authority all records and prop-**  
6 **erty within the jurisdiction of the executive director that relate to the**  
7 **duties, functions and powers transferred by section 6 of this 2014 Act;**  
8 **and**

9 **“(b) Transfer to the authority those employees engaged primarily**  
10 **in the exercise of the duties, functions and powers transferred by**  
11 **section 6 of this 2014 Act.**

12 **“(2) The Director of the Oregon Health Authority shall take pos-**  
13 **session of the records and property, and may take charge of the em-**  
14 **ployees and employ them in the exercise of the duties, functions and**  
15 **powers transferred by section 6 of this 2014 Act, subject to change or**  
16 **termination of employment or compensation as the director deems**  
17 **necessary.**

18 **“(3) The Governor shall resolve any dispute between the corporation**  
19 **and the authority relating to transfers of records, property and em-**  
20 **ployees under this section, and the Governor’s decision is final.**

21 **“SECTION 9. The transfer of duties, functions and powers to the**  
22 **Oregon Health Authority by section 6 of this 2014 Act does not affect**  
23 **any action, proceeding or prosecution involving or with respect to**  
24 **such duties, functions and powers begun before and pending at the**  
25 **time of the transfer, except that the authority is substituted for the**  
26 **Oregon Health Insurance Exchange Corporation in the action, pro-**  
27 **ceeding or prosecution.**

28 **“SECTION 10. (1) Nothing in sections 6 to 14 of this 2014 Act or the**  
29 **repeal of ORS 741.001, 741.002, 741.025, 741.027, 741.029, 741.031, 741.101,**  
30 **741.105, 741.201, 741.220, 741.222, 741.250, 741.255, 741.300, 741.310, 741.340,**

1 741.381, 741.390, 741.400, 741.500, 741.510, 741.520, 741.540 and 741.900 by  
2 section 45 of this 2014 Act relieves a person of a liability, duty or ob-  
3 ligation accruing under or with respect to the duties, functions and  
4 powers transferred by section 6 of this 2014 Act. The Oregon Health  
5 Authority may undertake the collection or enforcement of any such  
6 liability, duty or obligation.

7 “(2) The rights and obligations of the Oregon Health Insurance Ex-  
8 change Corporation legally incurred under contracts, leases and busi-  
9 ness transactions executed, entered into or begun before the operative  
10 date of section 6 of this 2014 Act are transferred to the authority. For  
11 the purpose of succession to these rights and obligations, the authority  
12 is a continuation of the corporation and not a new authority.

13 “SECTION 11. Notwithstanding the transfer of duties, functions and  
14 powers by section 6 of this 2014 Act, the rules of the Oregon Health  
15 Insurance Exchange Corporation in effect on the operative date of  
16 section 6 of this 2014 Act continue in effect until repealed by the  
17 Oregon Health Authority. References in rules of the corporation to the  
18 corporation or an officer or employee of the corporation are considered  
19 to be references to the authority or an officer or employee of the au-  
20 thority.

21 “SECTION 12. Whenever, in any statutory law or resolution of the  
22 Legislative Assembly or in any rule, document, record or proceeding  
23 authorized by the Legislative Assembly, reference is made to the  
24 Oregon Health Insurance Exchange Corporation or an officer or em-  
25 ployee of the corporation, the reference is considered to be a reference  
26 to the Oregon Health Authority or an officer or employee of the au-  
27 thority.

28 “SECTION 13. The Director of the Oregon Health Authority may  
29 take any action before the operative date of section 6 of this 2014 Act  
30 that is necessary to enable the director to exercise, on and after the

1 operative date of section 6 of this 2014 Act, the duties, functions and  
2 powers of the director pursuant to section 6 of this 2014 Act.

3 **“SECTION 14. For the purpose of harmonizing and clarifying stat-**  
4 **utory law, the Legislative Counsel may substitute for words designat-**  
5 **ing the ‘Oregon Health Insurance Exchange Corporation’ or its**  
6 **officers, wherever they occur in statutory law, words designating the**  
7 **‘Oregon Health Authority’ or its officers and may substitute for words**  
8 **designating the ‘executive director of the corporation,’ wherever they**  
9 **occur in statutory law, words designating the ‘Director of the Oregon**  
10 **Health Authority.**

11 **“SECTION 15. ORS 238.538 is amended to read:**

12 “238.538. (1) A judge member who elects to retire under ORS 238.535 (1)(b):

13 “(a) Shall continue to be eligible as a nonretired employee for health  
14 benefit plans, **subject to ORS 292.430**, [*contracted for under ORS 243.135*]  
15 during the time that the judge member is serving as a pro tem judge under  
16 ORS 238.535 (1)(c); and

17 “(b) Subject to availability of funding, shall continue to receive the  
18 monthly state contribution as payment of all or part of the cost of a health  
19 benefit plan during the time that the judge member is serving as a pro tem  
20 judge under ORS 238.535 (1)(c).

21 “(2) A judge member receiving the monthly state contribution as payment  
22 of all or part of the cost of a health benefit plan under this section is not  
23 eligible for payments against the cost of Medicare supplemental insurance  
24 under ORS 238.420 until such time as the judge member is no longer serving  
25 as a pro tem judge under ORS 238.535 (1)(c).

26 **“SECTION 16. ORS 243.129 is amended to read:**

27 “243.129. (1) The governing body of a local government may elect to partic-  
28 ipate in a benefit plan offered by the Public Employees’ Benefit Board.

29 “(2) The decision of the governing body of a local government to partic-  
30 ipate in a benefit plan offered by the board is in the discretion of the gov-

1 erning body of the local government and is a permissive subject of collective  
2 bargaining.

3 “(3) If the governing body of a local government elects to offer a benefit  
4 plan through the board, the governing body may elect one time only to pro-  
5 vide alternative group health and welfare insurance benefit plans to eligible  
6 employees if:

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

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

13 **“SECTION 17** ORS 243.135 is amended to read:

14 “243.135. (1) Notwithstanding any other benefit plan contracted for and  
15 offered by the Public Employees’ Benefit Board, the board shall contract for  
16 a health benefit plan or plans best designed to meet the needs and provide  
17 for the welfare of eligible employees, the state and the local governments.  
18 In considering whether to enter into a contract for a plan, the board shall  
19 place emphasis on:

20 “(a) Employee choice among high quality plans;

21 “(b) A competitive marketplace;

22 “(c) Plan performance and information;

23 “(d) Employer flexibility in plan design and contracting;

24 “(e) Quality customer service;

25 “(f) Creativity and innovation;

26 “(g) Plan benefits as part of total employee compensation; and

27 “(h) The improvement of employee health.

28 “(2) The board may approve more than one carrier for each type of plan  
29 contracted for and offered but the number of carriers shall be held to a  
30 number consistent with adequate service to eligible employees and their

1 family members.

2 “(3) Where appropriate for a contracted and offered health benefit plan,  
3 the board shall provide options under which an eligible employee may ar-  
4 range coverage for family members.

5 “(4) Payroll deductions for costs that are not payable by the state or a  
6 local government may be made upon receipt of a signed authorization from  
7 the employee indicating an election to participate in the plan or plans se-  
8 lected and the deduction of a certain sum from the employee’s pay.

9 “(5) In developing any health benefit plan, the board may provide an op-  
10 tion of additional coverage for eligible employees and their family members  
11 at an additional cost or premium.

12 “(6) Transfer of enrollment from one plan to another shall be open to all  
13 eligible employees and their family members under rules adopted by the  
14 board. Because of the special problems that may arise in individual instances  
15 under comprehensive group practice plan coverage involving acceptable  
16 physician-patient relations between a particular panel of physicians and  
17 particular eligible employees and their family members, the board shall pro-  
18 vide a procedure under which any eligible employee may apply at any time  
19 to substitute a health service benefit plan for participation in a comprehen-  
20 sive group practice benefit plan.

21 “(7) The board shall evaluate a benefit plan that serves a limited ge-  
22 ographic region of this state according to the criteria described in subsection  
23 (1) of this section.

24 “(8) **Notwithstanding ORS 741.310 (1), if a member of the Legislative**  
25 **Assembly elects to enroll in a health benefit plan offered by the board,**  
26 **the member must select a board-approved health benefit plan that is**  
27 **offered through the health insurance exchange administered by the**  
28 **Oregon Health Insurance Exchange Corporation under ORS 741.002.**

29 “(9) **If the Director of the Department of Consumer and Business**  
30 **Services, an administrator of any division of the department or an**

1 **employee of the department who is in management service, as de-**  
2 **scribed in ORS 240.212, elects to enroll in a health benefit plan offered**  
3 **by the board, the director, administrator or manager must select a**  
4 **board-approved health benefit plan that is offered through the health**  
5 **insurance exchange.**

6 **“SECTION 18.** ORS 243.142 is amended to read:

7 “243.142. The Oregon Health [*Insurance Exchange Corporation*] **Authority**  
8 shall apply for a waiver of federal law or any formal permission from the  
9 appropriate federal agency or agencies that is necessary to allow districts  
10 and eligible employees of districts to obtain health benefit plans through the  
11 [*health*] **federal** insurance exchange in accordance with ORS 243.886.

12 **“SECTION 19.** ORS 243.867 is amended to read:

13 “243.867. (1) The governing body of a local government may elect to par-  
14 ticipate in a benefit plan offered by the Oregon Educators Benefit Board.

15 “(2) The decision of the governing body of a local government to partic-  
16 ipate in a benefit plan offered by the board is in the discretion of the gov-  
17 erning body of the local government and is a permissive subject of collective  
18 bargaining.

19 “(3) If the governing body of a local government elects to offer a benefit  
20 plan through the board, the governing body may elect one time only to pro-  
21 vide alternative group health and welfare insurance benefit plans to eligible  
22 employees if:

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

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

29 **“SECTION 20.** ORS 243.886, as amended by section 13, chapter 38, Oregon  
30 Laws 2012, and section 2, chapter 780, Oregon Laws 2013, is amended to read:



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

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

7       “(b) Is offered through the [*health insurance exchange under ORS 741.310*  
8 *(1)(c)*] **federal insurance exchange established by the United States De-**  
9 **partment of Health and Human Services in accordance with 42 U.S.C.**  
10 **18041.**

11       “(2)(a) Except for community college districts, a district that was self-  
12 insured before January 1, 2007, or a district that had an independent health  
13 insurance trust established and functioning before January 1, 2007, may  
14 provide or contract for benefit plans other than benefit plans provided and  
15 administered by the board if the premiums for the benefit plans provided or  
16 contracted for by the district are equal to or less than the premiums for  
17 comparable benefit plans provided and administered by the board.

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

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

28       “(3)(a) A district, other than a district claiming the exception in sub-  
29 section (2)(a) of this section, that has not offered benefit plans provided and  
30 administered by the board before June 23, 2009, may provide or contract for

1 benefit plans other than benefit plans provided and administered by the  
2 board if the premiums for the benefit plans provided or contracted for by the  
3 district are equal to or less than the premiums for comparable benefit plans  
4 provided and administered by the board. Once employees of a district or an  
5 employee group within a district participates in benefit plans provided and  
6 administered by the board, the district may not thereafter provide or con-  
7 tract for benefit plans for those employees or employee groups other than  
8 those provided and administered by the board.

9 “(b) If requested by the district or a labor organization representing eli-  
10 gible employees of the district, the board shall perform an actuarial analysis  
11 of the district.

12 “(c) As used in this subsection, ‘district’ does not include a community  
13 college district.

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

16 **“SECTION 21.** ORS 291.229 is amended to read:

17 “291.229. (1) As part of the development of the legislatively adopted  
18 budget in each odd-numbered year regular session of the Legislative Assem-  
19 bly, the Oregon Department of Administrative Services shall make a report  
20 to the Joint Committee on Ways and Means on the actions taken by state  
21 agencies during the previous biennium to attain a ratio of at least 11 non-  
22 supervisory employees to every supervisory employee, as defined in ORS  
23 243.650.

24 “(2) As used in this section:

25 “(a) ‘State agency’ means all state officers, boards, commissions, depart-  
26 ments, institutions, branches, agencies, divisions and other entities, without  
27 regard to the designation given to those entities, that are within the execu-  
28 tive branch of government as described in Article III, section 1, of the  
29 Oregon Constitution.

30 “(b) ‘State agency’ does not include:

- 1 “(A) The legislative department as defined in ORS 174.114;  
2 “(B) The judicial department as defined in ORS 174.113;  
3 “(C) The Public Defense Services Commission;  
4 “(D) The Secretary of State and the State Treasurer in the performance  
5 of the duties of their constitutional offices;  
6 “(E) Semi-independent state agencies listed in ORS 182.454;  
7 “(F) The Oregon Tourism Commission;  
8 “(G) The Oregon Film and Video Office;  
9 “(H) The Oregon University System;  
10 “(I) The Oregon Health and Science University;  
11 “(J) The Travel Information Council;  
12 “(K) Oregon Corrections Enterprises;  
13 “(L) The Oregon State Lottery Commission;  
14 “(M) The State Accident Insurance Fund Corporation;  
15 “[*(N) The Oregon Health Insurance Exchange Corporation;*]  
16 “[*(O)*] **(N)** The Oregon Utility Notification Center;  
17 “[*(P)*] **(O)** Oregon Community Power;  
18 “[*(Q)*] **(P)** The Citizens’ Utility Board;  
19 “[*(R)*] **(Q)** A special government body as defined in ORS 174.117;  
20 “[*(S)*] **(R)** Any other public corporation created under a statute of this  
21 state and specifically designated as a public corporation; and  
22 “[*(T)*] **(S)** Any other semi-independent state agency denominated by stat-  
23 ute as a semi-independent state agency.

24 **“SECTION 22.** ORS 291.231 is amended to read:

25 “291.231. (1) Notwithstanding ORS 291.229, a state agency that employs  
26 more than 100 employees and has not, by April 11, 2012, attained a ratio of  
27 at least 11 to 1 of employees of the state agency who are not supervisory  
28 employees to supervisory employees:

29 “(a) May not fill the position of a supervisory employee until the agency  
30 has increased the agency’s ratio of employees to supervisory employees so

1 that the ratio is at least one additional employee to supervisory employees;  
2 and

3 “(b) Shall, not later than October 31, 2012, lay off or reclassify the number  
4 of supervisory employees necessary to attain the increase in the ratio speci-  
5 fied in paragraph (a) of this subsection if the increase in that ratio is not  
6 attained under paragraph (a) of this subsection or through attrition.

7 “(2) Notwithstanding ORS 291.229, a state agency that employs more than  
8 100 employees and has complied with the requirements of subsection (1) of  
9 this section, but has not attained a ratio of at least 11 to 1 of employees of  
10 the state agency who are not supervisory employees to supervisory employ-  
11 ees:

12 “(a) May not fill the position of a supervisory employee until the agency  
13 has increased the agency’s ratio of employees to supervisory employees by  
14 at least one additional employee; and

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

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

25 “(4) Upon application from a state agency, the Director of the Oregon  
26 Department of Administrative Services may grant a state agency an excep-  
27 tion from the requirements of subsections (1) to (3) of this section. The di-  
28 rector may grant an exception under this section that:

29 “(a) Applies to a particular position if the director determines the excep-  
30 tion is necessary to allow the state agency to maintain public or state agency

1 employee safety;

2 “(b) Applies to a division, unit, office, branch or other smaller part of the  
3 state agency if the director determines the exception is necessary to allow  
4 the state agency to maintain public or state agency employee safety or be-  
5 cause of the geographic location of the division, unit, office, branch or other  
6 smaller part of the state agency; or

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

12 “(5) Not later than five business days before the director proposes to  
13 grant an exception under this section, the director shall notify each collec-  
14 tive bargaining agent of the public or state agency employees in the appro-  
15 priate bargaining unit for the state agency requesting an exception.

16 “(6) The department shall report all exceptions granted under this sub-  
17 section to the Joint Committee on Ways and Means, the Joint Interim  
18 Committee on Ways and Means or the Emergency Board.

19 “(7) As used in this section:

20 “(a)(A) ‘State agency’ means all state officers, boards, commissions, de-  
21 partments, institutions, branches, agencies, divisions and other entities,  
22 without regard to the designation given to those entities, that are within the  
23 executive branch of government as described in Article III, section 1, of the  
24 Oregon Constitution.

25 “(B) ‘State agency’ does not include:

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

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

28 “(iii) The Public Defense Services Commission;

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

1 “(v) Semi-independent state agencies listed in ORS 182.454;  
2 “(vi) The Oregon Tourism Commission;  
3 “(vii) The Oregon Film and Video Office;  
4 “(viii) The Oregon University System;  
5 “(ix) The Oregon Health and Science University;  
6 “(x) The Travel Information Council;  
7 “(xi) Oregon Corrections Enterprises;  
8 “(xii) The Oregon State Lottery Commission;  
9 “(xiii) The State Accident Insurance Fund Corporation;  
10 “[*xiv*] *The Oregon Health Insurance Exchange Corporation*;  
11 “[*xv*] **(xiv)** The Oregon Utility Notification Center;  
12 “[*xvi*] **(xv)** Oregon Community Power;  
13 “[*xvii*] **(xvi)** The Citizens’ Utility Board;  
14 “[*xviii*] **(xvii)** A special government body as defined in ORS 174.117;  
15 “[*xix*] **(xviii)** Any other public corporation created under a statute of  
16 this state and specifically designated as a public corporation; and  
17 “[*xx*] **(xix)** Any other semi-independent state agency denominated by  
18 statute as a semi-independent state agency.

19 “(b) ‘Supervisory employee’ has the meaning given that term in ORS  
20 243.650.

21 **“SECTION 23.** ORS 292.430 is amended to read:

22 “292.430. (1) In addition to the annual salaries established as provided in  
23 ORS 292.907 to 292.930, the Oregon Department of Administrative Services  
24 may ‘pick-up,’ assume and pay to the Public Employees Retirement Fund any  
25 employee contributions, otherwise required by ORS 238.200, for the Governor,  
26 Secretary of State, State Treasurer, Attorney General, Commissioner of the  
27 Bureau of Labor and Industries and members of the Legislative Assembly.

28 “(2) The department may provide health, dental, life and long-term disa-  
29 bility insurance without cost to the officers referred to in subsection (1) of  
30 this section and to judges of the Supreme Court, Court of Appeals, Oregon

1 Tax Court and circuit courts in such amounts as are provided from time to  
2 time to employees in the unclassified service of the state.

3 **“(3) Notwithstanding ORS 741.310 (1), the department must purchase**  
4 **health and dental insurance under subsection (2) of this section that**  
5 **is offered through the health insurance exchange administered by the**  
6 **Oregon Health Insurance Exchange Corporation under ORS 741.002.**  
7 **To the extent that this subsection constitutes a reduction in compen-**  
8 **sation of a judge during the term for which the judge is elected, the**  
9 **Judicial Department shall reimburse the judge in an amount that off-**  
10 **sets the reduction.**

11 **“SECTION 24.** ORS 351.094 is amended to read:

12 “351.094. (1)(a) The State Board of Higher Education shall provide group  
13 insurance to employees of the Oregon University System through the Public  
14 Employees’ Benefit Board or may elect to provide an alternative group  
15 health and welfare insurance benefit plan to employees of the Oregon Uni-  
16 versity System on or after October 1, 2016, if the benefit plan is offered  
17 through the [*health insurance exchange under ORS 741.310*] **federal insur-**  
18 **ance exchange established by the United States Department of Health**  
19 **and Human Services in accordance with 42 U.S.C. 18041,** unless their  
20 participation is precluded by federal law.

21 “(b) The governing board of each university with a governing board listed  
22 in ORS 352.054 shall provide group insurance to employees of the university  
23 through the Public Employees’ Benefit Board or may elect to provide an al-  
24 ternative group health and welfare insurance benefit plan to employees of  
25 the university on or after October 1, 2016, if the benefit plan is offered  
26 through the [*health insurance exchange under ORS 741.310*] **federal insur-**  
27 **ance exchange described in paragraph (a) of this subsection,** unless  
28 their participation is precluded by federal law.

29 “(2) For the purposes of ORS 243.555 to 243.575, if the State Board of  
30 Higher Education or the governing board of a public university with a gov-

1 erning board listed in ORS 352.054 chooses not to participate in the benefit  
2 plans offered through the Public Employees' Benefit Board, the State Board  
3 of Higher Education or governing board may have the authority granted to  
4 the Public Employees' Benefit Board under ORS 243.555 to 243.575 for the  
5 administration of an appropriate expense reimbursement plan.

6 “(3)(a) The State Board of Higher Education shall offer one or more de-  
7 ferred compensation plans to employees of the Oregon University System.  
8 The Oregon University System shall, at the discretion of the board, choose  
9 whether to offer its employees the state deferred compensation plan estab-  
10 lished under ORS 243.401 to 243.507 or another deferred compensation plan  
11 that the board elects to make available to the employees of the Oregon  
12 University System.

13 “(b) The governing board of each public university with a governing board  
14 listed in ORS 352.054 shall offer one or more deferred compensation plans to  
15 employees of the university. The governing board shall choose whether to  
16 offer its employees the state deferred compensation plan established under  
17 ORS 243.401 to 243.507 or another deferred compensation plan that the gov-  
18 erning board elects to make available to the employees of the university.

19 **“SECTION 25.** ORS 411.400 is amended to read:

20 “411.400. (1) An application for any category of aid shall also constitute  
21 an application for medical assistance.

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

28 “(a) Over the Internet;

29 “(b) By telephone;

30 “(c) By mail;



1 “(d) In person; and

2 “(e) Through other commonly available electronic means.

3 “(3) The department and the authority may require an applicant or person  
4 acting on behalf of an applicant to provide only the information necessary  
5 for the purpose of making an eligibility determination or for a purpose di-  
6 rectly connected to the administration of medical assistance or the [*health*]  
7 **federal** insurance exchange.

8 “(4) The department and the authority shall provide application and re-  
9 certification assistance to individuals with disabilities, individuals with  
10 limited English proficiency, individuals facing physical or geographic barri-  
11 ers and individuals seeking help with the application for medical assistance  
12 or recertification of eligibility for medical assistance:

13 “(a) Over the Internet;

14 “(b) By telephone; and

15 “(c) In person.

16 “(5)(a) The department and the authority shall promptly transfer infor-  
17 mation received under this section to the [*Oregon Health Insurance Exchange*  
18 *Corporation*] **federal insurance exchange established by the United**  
19 **States Department of Health and Human Services in accordance with**  
20 **42 U.S.C. 18041** as necessary for the [*corporation*] **exchange** to determine  
21 eligibility for the exchange, premium tax credits or cost-sharing reductions.

22 “(b) The department shall promptly transfer information received under  
23 this section to the authority for individuals who are eligible for medical as-  
24 sistance because they qualify for public assistance.

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

29 **“SECTION 26.** ORS 411.402 is amended to read:

30 “411.402. (1) The Department of Human Services and the Oregon Health

1 Authority shall adopt by rule, consistent with federal requirements, the  
2 procedures for verifying eligibility for medical assistance, including but not  
3 limited to all of the following:

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

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

9 “(A) Pregnancy;

10 “(B) Date of birth;

11 “(C) Household composition; and

12 “(D) Residency.

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

15 “(d) The department and the authority may require the applicant to pro-  
16 vide verification in addition to the verification specified in this subsection  
17 only if the department and the authority are unable to obtain the informa-  
18 tion electronically or if the information obtained electronically is not rea-  
19 sonably compatible with information provided by or on behalf of the  
20 applicant.

21 “(e) The department and the authority shall use methods of adminis-  
22 tration that are in the best interests of applicants and recipients and that  
23 are necessary for the proper and efficient operation of the medical assistance  
24 program.

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

28 “(a) Verifying eligibility for medical assistance, participation in the [*ex-*  
29 *change*] **federal insurance exchange established by the United States**  
30 **Department of Health and Human Services in accordance with 42**

1 **U.S.C. 18041** or other health benefit programs;

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

4 “(c) Improving the provision of services; and

5 “(d) Administering health benefit programs.

6 **“SECTION 27.** ORS 411.406 is amended to read:

7 “411.406. (1) A medical assistance recipient shall immediately notify the  
8 Department of Human Services or the Oregon Health Authority, if required,  
9 of the receipt or possession of property or income or other change in cir-  
10 cumstances that directly affects the eligibility of the recipient to receive  
11 medical assistance, or that directly affects the amount of medical assistance  
12 for which the recipient is eligible. Failure to give the notice shall entitle the  
13 department or the authority to recover from the recipient the amount of as-  
14 sistance improperly disbursed by reason thereof.

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

17 “(b) The department and the authority shall redetermine eligibility under  
18 this subsection on the basis of information available to the department and  
19 the authority and may not require the recipient to provide information if the  
20 department or the authority is able to determine eligibility based on infor-  
21 mation in the recipient’s record or through other information that is avail-  
22 able to the department or the authority.

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

27 “(4) If the department or the authority determines that a medical assist-  
28 ance recipient no longer qualifies for the medical assistance program in  
29 which the recipient is enrolled, the department or the authority must deter-  
30 mine eligibility for other medical assistance programs, potential eligibility

1 for the [*health insurance exchange*] **federal insurance exchange estab-**  
2 **lished by the United States Department of Health and Human Services**  
3 **in accordance with 42 U.S.C. 18041**, premium tax credits and cost-sharing  
4 reductions before terminating the recipient’s medical assistance. If the re-  
5 cipient appears to qualify for the exchange, premium tax credits or cost-  
6 sharing reductions, the department or the authority shall promptly transfer  
7 the recipient’s record to the **federal insurance** exchange to process those  
8 benefits.

9 **“SECTION 28.** ORS 413.011 is amended to read:

10 “413.011. (1) The duties of the Oregon Health Policy Board are to:

11 “(a) Be the policy-making and oversight body for the Oregon Health Au-  
12 thority established in ORS 413.032 and all of the authority’s departmental  
13 divisions.

14 “[*(b) Develop and submit a plan to the Legislative Assembly by December*  
15 *31, 2010, to provide and fund access to affordable, quality health care for all*  
16 *Oregonians by 2015.*]

17 “[*(c)*] **(b)** Develop a program to provide health insurance premium assist-  
18 ance to all low and moderate income individuals who are legal residents of  
19 Oregon.

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

23 “[*(e)*] **(d)** Establish evidence-based clinical standards and practice guide-  
24 lines that may be used by providers.

25 “[*(f)*] **(e)** Approve and monitor community-centered health initiatives de-  
26 scribed in ORS 413.032 (1)(h) that are consistent with public health goals,  
27 strategies, programs and performance standards adopted by the Oregon  
28 Health Policy Board to improve the health of all Oregonians, and shall reg-  
29 ularly report to the Legislative Assembly on the accomplishments and needed  
30 changes to the initiatives.

1       “[(g)] (f) Establish cost containment mechanisms to reduce health care  
2 costs.

3       “[(h)] (g) Ensure that Oregon’s health care workforce is sufficient in  
4 numbers and training to meet the demand that will be created by the ex-  
5 pansion in health coverage, health care system transformations, an increas-  
6 ingly diverse population and an aging workforce.

7       “[(i)] (h) Work with the Oregon congressional delegation to advance the  
8 adoption of changes in federal law or policy to promote Oregon’s compre-  
9 hensive health reform plan.

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

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

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

17       “(B) A payroll tax as a means to encourage employers to continue pro-  
18 viding health insurance to their employees.

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

21       “[(L)] (j) Meet cost-containment goals by structuring reimbursement rates  
22 to reward comprehensive management of diseases, quality outcomes and the  
23 efficient use of resources by promoting cost-effective procedures, services and  
24 programs including, without limitation, preventive health, dental and pri-  
25 mary care services, web-based office visits, telephone consultations and tele-  
26 medicine consultations.

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

1       “[(n)] (L) Work with the Public Health Benefit Purchasers Committee,  
2 administrators of the medical assistance program and the Department of  
3 Corrections to identify uniform contracting standards for health benefit  
4 plans that achieve maximum quality and cost outcomes and align the con-  
5 tracting standards for all state programs to the greatest extent practicable.

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

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

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

16       “(3) If the board or the authority is unable to perform, in whole or in  
17 part, any of the duties described in ORS 413.006 to 413.042 [*and 741.340*]  
18 without federal approval, the authority is authorized to request, in accord-  
19 ance with ORS 413.072, waivers or other approval necessary to perform those  
20 duties. The authority shall implement any portions of those duties not re-  
21 quiring legislative authority or federal approval, to the extent practicable.

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

26       “(5) The board shall consult with the Department of Consumer and Busi-  
27 ness Services in completing the tasks set forth in subsection [(1)(j) *and*  
28 (k)(A)] (1)(i)(A) of this section.

29       “**SECTION 29.** ORS 413.017 is amended to read:

30       “413.017. (1) The Oregon Health Policy Board shall establish the commit-

1 tees described in subsections (2) and (3) of this section.

2 “(2)(a) The Public Health Benefit Purchasers Committee shall include in-  
3 dividuals who purchase health care for the following:

4 “(A) The Public Employees’ Benefit Board.

5 “(B) The Oregon Educators Benefit Board.

6 “(C) Trustees of the Public Employees Retirement System.

7 “(D) A city government.

8 “(E) A county government.

9 “(F) A special district.

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

12 “(b) The Public Health Benefit Purchasers Committee shall:

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

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

21 “(C) Continuously review and report to the Oregon Health Policy Board  
22 on the committee’s progress in aligning benefits while minimizing the cost  
23 shift to individual purchasers of insurance without shifting costs to the pri-  
24 vate sector or the [*Oregon Health Insurance Exchange*] **federal insurance**  
25 **exchange established by the United States Department of Health and**  
26 **Human Services in accordance with 42 U.S.C. 18041.**

27 “(c) The Oregon Health Policy Board shall work with the Public Health  
28 Benefit Purchasers Committee to identify uniform provisions for state and  
29 local public contracts for health benefit plans that achieve maximum quality  
30 and cost outcomes. The board shall collaborate with the committee to de-

1 velop steps to implement joint contract provisions. The committee shall  
2 identify a schedule for the implementation of contract changes. The process  
3 for implementation of joint contract provisions must include a review process  
4 to protect against unintended cost shifts to enrollees or agencies.

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

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

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

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

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

27 “**SECTION 30.** ORS 413.032 is amended to read:

28 “413.032. (1) The Oregon Health Authority is established. The authority  
29 shall:

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



1 “(b) Administer the Oregon Integrated and Coordinated Health Care De-  
2 livery System established in ORS 414.620;

3 “(c) Administer the Oregon Prescription Drug Program;

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

6 “(e) Develop the policies for and the provision of mental health treatment  
7 and treatment of addictions;

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

10 “(g) Provide regular reports to the board with respect to the performance  
11 of health services contractors serving recipients of medical assistance, in-  
12 cluding reports of trends in health services and enrollee satisfaction;

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

16 “(i) Be the state Medicaid agency for the administration of funds from  
17 Titles XIX and XXI of the Social Security Act and administer medical as-  
18 sistance under ORS chapter 414;

19 “(j) In consultation with the Director of the Department of Consumer and  
20 Business Services, periodically review and recommend standards and meth-  
21 odologies to the Legislative Assembly for:

22 “(A) Review of administrative expenses of health insurers;

23 “(B) Approval of rates; and

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

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

1 consultations and telemedicine consultations;

2 “(L) Guide and support community three-share agreements in which an  
3 employer, state or local government and an individual all contribute a por-  
4 tion of a premium for a community-centered health initiative or for insur-  
5 ance coverage;

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

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

11 “(2) The Oregon Health Authority is authorized to:

12 “(a) Create an all-claims, all-payer database to collect health care data  
13 and monitor and evaluate health care reform in Oregon and to provide  
14 comparative cost and quality information to consumers, providers and pur-  
15 chasers of health care about Oregon’s health care systems and health plan  
16 networks in order to provide comparative information to consumers.

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

19 “(A) Uniform quality standards and performance measures;

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

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

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

26 “(3) The enumeration of duties, functions and powers in this section is  
27 not intended to be exclusive nor to limit the duties, functions and powers  
28 imposed on or vested in the Oregon Health Authority by ORS 413.006 to  
29 413.042 [*and 741.340*] or by other statutes.

30 “**SECTION 31.** ORS 413.037 is amended to read:

1 “413.037. (1) The Director of the Oregon Health Authority, each deputy  
2 director and authorized representatives of the director may administer oaths,  
3 take depositions and issue subpoenas to compel the attendance of witnesses  
4 and the production of documents or other written information necessary to  
5 carry out the provisions of ORS 413.006 to 413.042 [*and 741.340*].

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

10 **“SECTION 32.** ORS 413.085 is amended to read:

11 “413.085. The Director of Human Services[, *the executive director of the*  
12 *Oregon Health Insurance Exchange Corporation*] and the Director of the  
13 Oregon Health Authority may delegate to each other by interagency agree-  
14 ment any duties, functions or powers granted to the Department of Human  
15 Services[, *the corporation*] or the Oregon Health Authority by law, as the  
16 directors deem necessary for the efficient and effective operation of the re-  
17 spective functions of the department[, *the corporation*] and the authority.

18 **“SECTION 33.** ORS 414.115 is amended to read:

19 “414.115. (1) In lieu of providing one or more of the health care and ser-  
20 vices available under medical assistance by direct payments to providers  
21 thereof and in lieu of providing such health care and services made available  
22 pursuant to ORS 414.065, the Oregon Health Authority may use available  
23 medical assistance funds to purchase and pay premiums on policies of in-  
24 surance, or enter into and pay the expenses on health care service contracts,  
25 or medical or hospital service contracts that provide one or more of the  
26 health care and services available under medical assistance. Notwithstanding  
27 other specific provisions, the use of available medical assistance funds to  
28 purchase health care and services may provide the following insurance or  
29 contract options:

30 “(a) Differing services or levels of service among groups of eligibles as

1 defined by rules of the authority; and

2 “(b) Services and reimbursement for these services may vary among con-  
3 tracts and need not be uniform.

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

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

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

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

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

20 “(3) The authority may purchase insurance under this section through the  
21 [*health insurance exchange*] **federal insurance exchange established by**  
22 **the United States Department of Health and Human Services in ac-**  
23 **cordance with 42 U.S.C. 18041.**

24 “**SECTION 34.** ORS 414.826 is amended to read:

25 “414.826. (1) As used in this section:

26 “(a) ‘Child’ means a person under 19 years of age who is lawfully present  
27 in this state.

28 “(b) ‘Dental plan’ means a policy or certificate of group or individual  
29 health insurance, as defined in ORS 731.162, providing payment or re-  
30 imbursement only for the expenses of dental care.

1 “(c) ‘Health benefit plan’ has the meaning given that term in ORS 743.730.

2 “(2) The Oregon Health Authority shall administer a private health op-  
3 tion to expand access to private health insurance for Oregon’s children.

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

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

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

13 “(c) Expenditures for the health benefit plan qualify for federal financial  
14 participation.

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

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

19 “(b) Expenditures for the dental plan must qualify for federal financial  
20 participation.

21 “(5) The amount of premium assistance provided under this section shall  
22 be:

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

27 “(b) Based on a sliding scale under criteria established by the authority  
28 by rule for children whose family income is above 200 percent but at or be-  
29 low 300 percent of the federal poverty guidelines, regardless of whether the  
30 child has access to coverage under an employer sponsored health benefit plan

1 or dental plan.

2 “(6) Premium assistance may be available under this section to a child  
3 described in subsection (5)(b) of this section for a health benefit plan pur-  
4 chased through the [*Oregon health insurance exchange*] **federal insurance**  
5 **exchange established by the United States Department of Health and**  
6 **Human Services in accordance with 42 U.S.C. 18041.**

7 “**NOTE:** Sections 35 and 36 were deleted. Subsequent sections were not  
8 renumbered.

9 “**SECTION 37.** ORS 743.730 is amended to read:

10 “743.730. For purposes of ORS 743.730 to 743.773:

11 “(1) ‘Actuarial certification’ means a written statement by a member of  
12 the American Academy of Actuaries or other individual acceptable to the  
13 Director of the Department of Consumer and Business Services that a carrier  
14 is in compliance with the provisions of ORS 743.736 based upon the person’s  
15 examination, including a review of the appropriate records and of the  
16 actuarial assumptions and methods used by the carrier in establishing pre-  
17 mium rates for small employer health benefit plans.

18 “(2) ‘Affiliate’ of, or person ‘affiliated’ with, a specified person means any  
19 carrier who, directly or indirectly through one or more intermediaries, con-  
20 trols or is controlled by or is under common control with a specified person.  
21 For purposes of this definition, ‘control’ has the meaning given that term in  
22 ORS 732.548.

23 “(3) ‘Affiliation period’ means, under the terms of a group health benefit  
24 plan issued by a health care service contractor, a period:

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

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

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

1 “(d) That begins on the enrollee’s or late enrollee’s first date of eligibility  
2 for coverage and runs concurrently with any eligibility waiting period under  
3 the plan.

4 “(4) ‘Bona fide association’ means an association that:

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

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

8 “(c) Does not condition membership in the association on any factor re-  
9 lating to the health status of an individual or the individual’s dependent or  
10 employee;

11 “(d) Makes health insurance coverage that is offered through the associ-  
12 ation available to all members of the association regardless of the health  
13 status of the member or individuals who are eligible for coverage through  
14 the member;

15 “(e) Does not make health insurance coverage that is offered through the  
16 association available other than in connection with a member of the associ-  
17 ation;

18 “(f) Has a constitution and bylaws; and

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

21 “(5) ‘Carrier’ means any person who provides health benefit plans in this  
22 state, including:

23 “(a) A licensed insurance company;

24 “(b) A health care service contractor;

25 “(c) A health maintenance organization;

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

28 “(A) Is subject to ORS 750.301 to 750.341; or

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

1 “(e) Any other person or corporation responsible for the payment of ben-  
2 efits or provision of services.

3 “(6) ‘Catastrophic plan’ means a health benefit plan that meets the re-  
4 quirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is of-  
5 fered through the [*Oregon health insurance*] exchange.

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

9 “(8) ‘Dependent’ means the spouse or child of an eligible employee, subject  
10 to applicable terms of the health benefit plan covering the employee.

11 “(9) ‘Eligible employee’ means an employee who works on a regularly  
12 scheduled basis, with a normal work week of 17.5 or more hours. The em-  
13 ployer may determine hours worked for eligibility between 17.5 and 40 hours  
14 per week subject to rules of the carrier. ‘Eligible employee’ does not include  
15 employees who work on a temporary, seasonal or substitute basis. Employees  
16 who have been employed by the employer for fewer than 90 days are not el-  
17 igible employees unless the employer so allows.

18 “(10) ‘Employee’ means any individual employed by an employer.

19 “(11) ‘Enrollee’ means an employee, dependent of the employee or an in-  
20 dividual otherwise eligible for a group or individual health benefit plan who  
21 has enrolled for coverage under the terms of the plan.

22 “(12) ‘Exchange’ means the [*health insurance exchange administered by the*  
23 *Oregon Health Insurance Exchange Corporation in accordance with ORS*  
24 *741.310*] **federal insurance exchange established by the United States**  
25 **Department of Health and Human Services in accordance with 42**  
26 **U.S.C. 18041.**

27 “(13) ‘Exclusion period’ means a period during which specified treatments  
28 or services are excluded from coverage.

29 “(14) ‘Financial impairment’ means that a carrier is not insolvent and is:

30 “(a) Considered by the director to be potentially unable to fulfill its con-



1 tractual obligations; or

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

4 “(15)(a) ‘Geographic average rate’ means the arithmetical average of the  
5 lowest premium and the corresponding highest premium to be charged by a  
6 carrier in a geographic area established by the director for the carrier’s:

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

8 “(B) Individual health benefit plans.

9 “(b) ‘Geographic average rate’ does not include premium differences that  
10 are due to differences in benefit design, age, tobacco use or family composi-  
11 tion.

12 “(16) ‘Grandfathered health plan’ has the meaning prescribed by the  
13 United States Secretaries of Labor, Health and Human Services and the  
14 Treasury pursuant to 42 U.S.C. 18011(e).

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

18 “(18)(a) ‘Health benefit plan’ means any:

19 “(A) Hospital expense, medical expense or hospital or medical expense  
20 policy or certificate;

21 “(B) Health care service contractor or health maintenance organization  
22 subscriber contract; or

23 “(C) Plan provided by a multiple employer welfare arrangement or by  
24 another benefit arrangement defined in the federal Employee Retirement In-  
25 come Security Act of 1974, as amended, to the extent that the plan is subject  
26 to state regulation.

27 “(b) ‘Health benefit plan’ does not include:

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

30 “(B) Coverage of Medicare services pursuant to contracts with the federal

1 government;

2 “(C) Medicare supplement insurance policies;

3 “(D) Coverage of TRICARE services pursuant to contracts with the fed-  
4 eral government;

5 “(E) Benefits delivered through a flexible spending arrangement estab-  
6 lished pursuant to section 125 of the Internal Revenue Code of 1986, as  
7 amended, when the benefits are provided in addition to a group health ben-  
8 efit plan;

9 “(F) Separately offered long term care insurance, including, but not lim-  
10 ited to, coverage of nursing home care, home health care and community-  
11 based care;

12 “(G) Independent, noncoordinated, hospital-only indemnity insurance or  
13 other fixed indemnity insurance;

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

16 “(I) Dental only coverage;

17 “(J) Vision only coverage;

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

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

20 “(M) Insurance arising out of a workers’ compensation or similar law;

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

25 “(O) Any employee welfare benefit plan that is exempt from state regu-  
26 lation because of the federal Employee Retirement Income Security Act of  
27 1974, as amended.

28 “(c) For purposes of this subsection, renewal of a short term health in-  
29 surance policy includes the issuance of a new short term health insurance  
30 policy by an insurer to a policyholder within 60 days after the expiration of

1 a policy previously issued by the insurer to the policyholder.

2 “(19) ‘Individual coverage waiting period’ means a period in an individual  
3 health benefit plan during which no premiums may be collected and health  
4 benefit plan coverage issued is not effective.

5 “(20) ‘Individual health benefit plan’ means a health benefit plan:

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

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

9 “(21) ‘Initial enrollment period’ means a period of at least 30 days fol-  
10 lowing commencement of the first eligibility period for an individual.

11 “(22) ‘Late enrollee’ means an individual who enrolls in a group health  
12 benefit plan subsequent to the initial enrollment period during which the  
13 individual was eligible for coverage but declined to enroll. However, an eli-  
14 gible individual shall not be considered a late enrollee if:

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

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

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

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

26 “(e) The individual’s coverage under Medicaid, Medicare, TRICARE, In-  
27 dian Health Service or a publicly sponsored or subsidized health plan, in-  
28 cluding, but not limited to, the medical assistance program under ORS  
29 chapter 414, has been involuntarily terminated within 63 days after applying  
30 for coverage in a group health benefit plan.

1 “(23) ‘Minimal essential coverage’ has the meaning given that term in  
2 section 5000A(f) of the Internal Revenue Code.

3 “(24) ‘Multiple employer welfare arrangement’ means a multiple employer  
4 welfare arrangement as defined in section 3 of the federal Employee Retire-  
5 ment Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject  
6 to ORS 750.301 to 750.341.

7 “(25) ‘Preexisting condition exclusion’ means:

8 “(a) Except for a grandfathered health plan, a limitation or exclusion of  
9 benefits or a denial of coverage based on a medical condition being present  
10 before the effective date of coverage or before the date coverage is denied,  
11 whether or not any medical advice, diagnosis, care or treatment was recom-  
12 mended or received for the condition before the date of coverage or denial  
13 of coverage.

14 “(b) With respect to a grandfathered health plan, a provision applicable  
15 to an enrollee or late enrollee that excludes coverage for services, charges  
16 or expenses incurred during a specified period immediately following enroll-  
17 ment for a condition for which medical advice, diagnosis, care or treatment  
18 was recommended or received during a specified period immediately preced-  
19 ing enrollment. For purposes of this paragraph pregnancy and genetic infor-  
20 mation do not constitute preexisting conditions.

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

24 “(27) ‘Rating period’ means the 12-month calendar period for which pre-  
25 mium rates established by a carrier are in effect, as determined by the car-  
26 rier.

27 “(28) ‘Representative’ does not include an insurance producer or an em-  
28 ployee or authorized representative of an insurance producer or carrier.

29 “(29)(a) ‘Small employer’ means an employer that employed an average of  
30 at least one but not more than 50 employees on business days during the

1 preceding calendar year, the majority of whom are employed within this  
2 state, and that employs at least one eligible employee on the first day of the  
3 plan year.

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

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

11 **“SECTION 38.** ORS 743.730, as amended by section 59, chapter 681,  
12 Oregon Laws 2013, is amended to read:

13 “743.730. For purposes of ORS 743.730 to 743.773:

14 “(1) ‘Actuarial certification’ means a written statement by a member of  
15 the American Academy of Actuaries or other individual acceptable to the  
16 Director of the Department of Consumer and Business Services that a carrier  
17 is in compliance with the provisions of ORS 743.736 based upon the person’s  
18 examination, including a review of the appropriate records and of the  
19 actuarial assumptions and methods used by the carrier in establishing pre-  
20 mium rates for small employer health benefit plans.

21 “(2) ‘Affiliate’ of, or person ‘affiliated’ with, a specified person means any  
22 carrier who, directly or indirectly through one or more intermediaries, con-  
23 trols or is controlled by or is under common control with a specified person.  
24 For purposes of this definition, ‘control’ has the meaning given that term in  
25 ORS 732.548.

26 “(3) ‘Affiliation period’ means, under the terms of a group health benefit  
27 plan issued by a health care service contractor, a period:

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

30 “(b) That must expire before any coverage becomes effective under the

1 plan for the enrollee or late enrollee;

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

4 “(d) That begins on the enrollee’s or late enrollee’s first date of eligibility  
5 for coverage and runs concurrently with any eligibility waiting period under  
6 the plan.

7 “(4) ‘Bona fide association’ means an association that:

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

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

11 “(c) Does not condition membership in the association on any factor re-  
12 lating to the health status of an individual or the individual’s dependent or  
13 employee;

14 “(d) Makes health insurance coverage that is offered through the associ-  
15 ation available to all members of the association regardless of the health  
16 status of the member or individuals who are eligible for coverage through  
17 the member;

18 “(e) Does not make health insurance coverage that is offered through the  
19 association available other than in connection with a member of the associ-  
20 ation;

21 “(f) Has a constitution and bylaws; and

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

24 “(5) ‘Carrier’ means any person who provides health benefit plans in this  
25 state, including:

26 “(a) A licensed insurance company;

27 “(b) A health care service contractor;

28 “(c) A health maintenance organization;

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

1 “(A) Is subject to ORS 750.301 to 750.341; or

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

4 “(e) Any other person or corporation responsible for the payment of ben-  
5 efits or provision of services.

6 “(6) ‘Catastrophic plan’ means a health benefit plan that meets the re-  
7 quirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is of-  
8 fered through the [*Oregon health insurance*] exchange.

9 “(7) ‘Creditable coverage’ means prior health care coverage as defined in  
10 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes  
11 coverage remaining in force at the time the enrollee obtains new coverage.

12 “(8) ‘Dependent’ means the spouse or child of an eligible employee, subject  
13 to applicable terms of the health benefit plan covering the employee.

14 “(9) ‘Eligible employee’ means an employee who works on a regularly  
15 scheduled basis, with a normal work week of 17.5 or more hours. The em-  
16 ployer may determine hours worked for eligibility between 17.5 and 40 hours  
17 per week subject to rules of the carrier. ‘Eligible employee’ does not include  
18 employees who work on a temporary, seasonal or substitute basis. Employees  
19 who have been employed by the employer for fewer than 90 days are not el-  
20 igible employees unless the employer so allows.

21 “(10) ‘Employee’ means any individual employed by an employer.

22 “(11) ‘Enrollee’ means an employee, dependent of the employee or an in-  
23 dividual otherwise eligible for a group or individual health benefit plan who  
24 has enrolled for coverage under the terms of the plan.

25 “(12) ‘Exchange’ means the [*health insurance exchange administered by the*  
26 *Oregon Health Insurance Exchange Corporation in accordance with ORS*  
27 **741.310] **federal insurance exchange established by the United States****  
28 **Department of Health and Human Services in accordance with 42**  
29 **U.S.C. 18041.**

30 “(13) ‘Exclusion period’ means a period during which specified treatments

1 or services are excluded from coverage.

2 “(14) ‘Financial impairment’ means that a carrier is not insolvent and is:

3 “(a) Considered by the director to be potentially unable to fulfill its con-  
4 tractual obligations; or

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

7 “(15)(a) ‘Geographic average rate’ means the arithmetical average of the  
8 lowest premium and the corresponding highest premium to be charged by a  
9 carrier in a geographic area established by the director for the carrier’s:

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

11 “(B) Individual health benefit plans.

12 “(b) ‘Geographic average rate’ does not include premium differences that  
13 are due to differences in benefit design, age, tobacco use or family composi-  
14 tion.

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

18 “(17) ‘Group eligibility waiting period’ means, with respect to a group  
19 health benefit plan, the period of employment or membership with the group  
20 that a prospective enrollee must complete before plan coverage begins.

21 “(18)(a) ‘Health benefit plan’ means any:

22 “(A) Hospital expense, medical expense or hospital or medical expense  
23 policy or certificate;

24 “(B) Health care service contractor or health maintenance organization  
25 subscriber contract; or

26 “(C) Plan provided by a multiple employer welfare arrangement or by  
27 another benefit arrangement defined in the federal Employee Retirement In-  
28 come Security Act of 1974, as amended, to the extent that the plan is subject  
29 to state regulation.

30 “(b) ‘Health benefit plan’ does not include:



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

3       “(B) Coverage of Medicare services pursuant to contracts with the federal  
4 government;

5       “(C) Medicare supplement insurance policies;

6       “(D) Coverage of TRICARE services pursuant to contracts with the fed-  
7 eral government;

8       “(E) Benefits delivered through a flexible spending arrangement estab-  
9 lished pursuant to section 125 of the Internal Revenue Code of 1986, as  
10 amended, when the benefits are provided in addition to a group health ben-  
11 efit plan;

12       “(F) Separately offered long term care insurance, including, but not lim-  
13 ited to, coverage of nursing home care, home health care and community-  
14 based care;

15       “(G) Independent, noncoordinated, hospital-only indemnity insurance or  
16 other fixed indemnity insurance;

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

19       “(I) Dental only coverage;

20       “(J) Vision only coverage;

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

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

23       “(M) Insurance arising out of a workers’ compensation or similar law;

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

28       “(O) Any employee welfare benefit plan that is exempt from state regu-  
29 lation because of the federal Employee Retirement Income Security Act of  
30 1974, as amended.

1       “(c) For purposes of this subsection, renewal of a short term health in-  
2       surance policy includes the issuance of a new short term health insurance  
3       policy by an insurer to a policyholder within 60 days after the expiration of  
4       a policy previously issued by the insurer to the policyholder.

5       “(19) ‘Individual coverage waiting period’ means a period in an individual  
6       health benefit plan during which no premiums may be collected and health  
7       benefit plan coverage issued is not effective.

8       “(20) ‘Individual health benefit plan’ means a health benefit plan:

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

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

12       “(21) ‘Initial enrollment period’ means a period of at least 30 days fol-  
13       lowing commencement of the first eligibility period for an individual.

14       “(22) ‘Late enrollee’ means an individual who enrolls in a group health  
15       benefit plan subsequent to the initial enrollment period during which the  
16       individual was eligible for coverage but declined to enroll. However, an eli-  
17       gible individual shall not be considered a late enrollee if:

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

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

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

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

29       “(e) The individual’s coverage under Medicaid, Medicare, TRICARE, In-  
30       dian Health Service or a publicly sponsored or subsidized health plan, in-

1 cluding, but not limited to, the medical assistance program under ORS  
2 chapter 414, has been involuntarily terminated within 63 days after applying  
3 for coverage in a group health benefit plan.

4 “(23) ‘Minimal essential coverage’ has the meaning given that term in  
5 section 5000A(f) of the Internal Revenue Code.

6 “(24) ‘Multiple employer welfare arrangement’ means a multiple employer  
7 welfare arrangement as defined in section 3 of the federal Employee Retire-  
8 ment Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject  
9 to ORS 750.301 to 750.341.

10 “(25) ‘Preexisting condition exclusion’ means:

11 “(a) Except for a grandfathered health plan, a limitation or exclusion of  
12 benefits or a denial of coverage based on a medical condition being present  
13 before the effective date of coverage or before the date coverage is denied,  
14 whether or not any medical advice, diagnosis, care or treatment was recom-  
15 mended or received for the condition before the date of coverage or denial  
16 of coverage.

17 “(b) With respect to a grandfathered health plan, a provision applicable  
18 to an enrollee or late enrollee that excludes coverage for services, charges  
19 or expenses incurred during a specified period immediately following enroll-  
20 ment for a condition for which medical advice, diagnosis, care or treatment  
21 was recommended or received during a specified period immediately preced-  
22 ing enrollment. For purposes of this paragraph pregnancy and genetic infor-  
23 mation do not constitute preexisting conditions.

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

27 “(27) ‘Rating period’ means the 12-month calendar period for which pre-  
28 mium rates established by a carrier are in effect, as determined by the car-  
29 rier.

30 “(28) ‘Representative’ does not include an insurance producer or an em-

1    ployee or authorized representative of an insurance producer or carrier.

2       “(29)(a) ‘Small employer’ means an employer that employed an average of  
3    at least one but not more than 100 employees on business days during the  
4    preceding calendar year, the majority of whom are employed within this  
5    state, and that employs at least one eligible employee on the first day of the  
6    plan year.

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

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

14      “**SECTION 39.** ORS 743.733 is amended to read:

15      “743.733. (1) If an affiliated group of employers is treated as a single em-  
16    ployer under section 414 (b), (c), (m) or (o) of the Internal Revenue Code of  
17    1986, a carrier may issue a single group health benefit plan to the affiliated  
18    group on the basis of the number of employees in the affiliated group if the  
19    group requests such coverage.

20      “(2) Subsequent to the issuance of a health benefit plan to a small em-  
21    ployer, other than a plan issued through the [*Oregon health insurance*] ex-  
22    change, a carrier shall determine annually the number of employees of the  
23    employer for purposes of determining the employer’s ongoing eligibility as a  
24    small employer.

25      “(3)(a) ORS 743.733 to 743.737 shall continue to apply to a health benefit  
26    plan issued outside of the exchange to a small employer until the plan an-  
27    niversary date following the date the employer no longer meets the definition  
28    of a small employer.

29      “(b) ORS 743.733 to 743.737 shall continue to apply to an employer that  
30    receives coverage through the exchange until the employer no longer re-

1 ceives coverage through the exchange and is no longer a small employer.

2 **“SECTION 40.** ORS 743.822 is amended to read:

3 “743.822. (1) In each individual or small group market, in which a carrier  
4 offers a health benefit plan through or outside of the [*Oregon health insur-*  
5 *ance exchange*] **federal insurance exchange established by the United**  
6 **States Department of Health and Human Services in accordance with**  
7 **42 U.S.C. 18041**, the carrier must offer to residents of this state a bronze and  
8 a silver plan approved by the [*Department of Consumer and Business Services*  
9 *as meeting the requirements of subsection (2) of this section*] **United States**  
10 **Department of Health and Human Services.**

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

14 “[*(3)*] (2) As used in this section, ‘health benefit plan’ has the meaning  
15 given that term in ORS 743.730.

16 **“SECTION 41.** ORS 743.826 is amended to read:

17 “743.826. A carrier may offer a catastrophic plan only through the [*ex-*  
18 *change*] **federal insurance exchange established by the United States**  
19 **Department of Health and Human Services in accordance with 42**  
20 **U.S.C. 18041** and only to an individual who:

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

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

24 **“SECTION 42.** Section 11, chapter 8, Oregon Laws 2012, as amended by  
25 section 2, chapter 368, Oregon Laws 2013, is amended to read:

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

29 “(1) On the implementation of the Oregon Integrated and Coordinated  
30 Care Delivery System;

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

3 “(3) For the purpose of developing a baseline with which to compare fu-  
4 ture costs, per member costs for each category of service; **and**

5 “(4) The administrative costs to the authority in the implementation of  
6 the system and the aggregate financial information reported to the authority  
7 by coordinated care organizations, including but not limited to the coordi-  
8 nated care organizations’:

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

11 “(b) Reserves, projected cash flows and other financial information pre-  
12 scribed by the authority by rule.[: and]

13 “[5] *On efforts made, in collaboration with the Oregon Health Insurance*  
14 *Exchange Corporation, to coordinate eligibility determination and enrollment*  
15 *processes for qualified health plans and the state medical assistance*  
16 *program.*]

17 **“SECTION 43.** Section 1, chapter 712, Oregon Laws 2013, is amended to  
18 read:

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

21 “(a) Provides universal access to comprehensive care at the appropriate  
22 time.

23 “(b) Ensures transparency and accountability.

24 “(c) Enhances primary care.

25 “(d) Allows the choice of health care provider.

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

27 “(f) Provides for continuous improvement of health care quality and  
28 safety.

29 “(g) Reduces administrative costs.

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

- 1 “(i) Ensures adequate compensation of health care providers.
- 2 “(j) Incorporates community-based systems.
- 3 “(k) Includes effective cost controls.
- 4 “(L) Provides universal access to care even if the person is outside of  
5 Oregon.
- 6 “(m) Provides seamless birth-to-death access to care.
- 7 “(n) Minimizes medical errors.
- 8 “(o) Focuses on preventative health care.
- 9 “(p) Integrates physical, dental, vision and mental health care.
- 10 “(q) Includes long term care.
- 11 “(r) Provides equitable access to health care, according to a person’s  
12 needs.
- 13 “(s) Is affordable for individuals, families, businesses and society.
- 14 “(2) To the extent practicable using only the funds received under section  
15 **2, chapter 712, Oregon Laws 2013** [*of this 2013 Act*], the Oregon Health  
16 Authority shall contract with a third party to conduct a study overseen by  
17 the authority to examine at least four options for financing health care de-  
18 livery in this state, including:
- 19 “(a) An option for a publicly financed single-payer model for financing  
20 privately delivered health care, that is decoupled from employment and al-  
21 lows commercial insurance coverage only of supplemental health services not  
22 paid for under the option.
- 23 “(b) An option that allows a person to choose between a publicly funded  
24 plan, including a basic health program under 42 U.S.C. 18051, and private  
25 insurance coverage and allows for fair and robust competition among public  
26 plans and private insurance.
- 27 “(c) The current health care financing system in this state, including the:  
28 “(A) Oregon Integrated and Coordinated Health Care Delivery System;  
29 **and**
- 30 “[*B*] Oregon health insurance exchange; and]

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

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

6        “(A) Allows a person to access the commercial market to purchase cov-  
7 erage that is not covered under the plan;

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

11        “(C) Offers to Oregonians who earn more than 400 percent of the federal  
12 poverty guidelines a deductible plan that could be contributed to by em-  
13 ployees and employers;

14        “(D) Exempts Oregonians who earn no more than 400 percent of the fed-  
15 eral poverty guidelines from deductibles;

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

17        “(F) Identifies program savings that can be achieved by providing health  
18 care coverage to all Oregonians, including but not limited to using the pro-  
19 gram to replace the state medical assistance program and the medical portion  
20 of worker’s compensation, then applies the savings to finance the plan.

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

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

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

26        “(c) This state’s current health care reform efforts.

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

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



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

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

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

5 “(a) Analyzes the costs and benefits of requiring copayments and of not  
6 requiring copayments.

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

10 “(c) For each option:

11 “(A) Evaluates the extent to which the option satisfies the criteria de-  
12 scribed in subsection (1) of this section;

13 “(B) Estimates the cost of implementation, including anticipated costs  
14 from increased services, more patients, new facilities and savings from effi-  
15 ciencies;

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

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

20 “(E) Assesses the impact of implementation on the economy of this state;  
21 and

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

25 “(5) The report must include a recommendation for the option for health  
26 care delivery and financing that best satisfies the criteria described in sub-  
27 section (1) of this section and that:

28 “(a) Maximizes available federal funding; and

29 “(b) Ensures that health care providers receive adequate compensation for  
30 providing health care.

1       **“SECTION 44. (1) Sections 6 to 14 of this 2014 Act and the amend-**  
2 **ments to ORS 243.129, 243.142, 243.867, 243.886, 291.229, 291.231, 351.094,**  
3 **411.400, 411.402, 411.406, 413.011, 413.017, 413.032, 413.037, 413.085, 414.115,**  
4 **414.826, 743.730, 743.733, 743.822 and 743.826 and section 11, chapter 8,**  
5 **Oregon Laws 2012, and section 1, chapter 712, Oregon Laws 2013, by**  
6 **sections 16, 18 to 22, 24 to 34 and 37 to 43 of this 2014 Act become op-**  
7 **erative 30 days after the effective date of this 2014 Act.**

8       **“(2) The amendments to ORS 238.538, 243.135 and 292.430 by sections**  
9 **15, 17 and 23 of this 2014 Act become operative January 1, 2017.**

10       **“SECTION 45. (1)(a) ORS 741.001, 741.002, 741.025, 741.027, 741.029,**  
11 **741.031, 741.101, 741.105, 741.201, 741.220, 741.222, 741.250, 741.255, 741.300,**  
12 **741.310, 741.340, 741.381, 741.400, 741.500, 741.510, 741.520 and 741.540 and**  
13 **section 14, chapter 38, Oregon Laws 2012, and section 4, chapter 368,**  
14 **Oregon Laws 2013, are repealed 30 days after the effective date of this**  
15 **2014 Act.**

16       **“(b) Section 27, chapter 415, Oregon Laws 2011, as amended by sec-**  
17 **tion 8, chapter 38, Oregon Laws 2012, is repealed 30 days after the ef-**  
18 **fective date of this 2014 Act.**

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

20       **“SECTION 46. This 2014 Act being necessary for the immediate**  
21 **preservation of the public peace, health and safety, an emergency is**  
22 **declared to exist, and this 2014 Act takes effect on its passage.”.**

23