House Bill 2203

Sponsored by Representative GREENLICK (Presession filed.)

SUMMARY

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

Modifies duties of Oregon Health Insurance Exchange Corporation and authorizes use of federal technology for health insurance exchange. Removes responsibility of corporation for functions assumed by federal health insurance exchange and for determining eligibility for medical assistance.

Declares emergency, effective on passage.

1 **A BILL FOR AN ACT**

2 Relating to the health insurance exchange; creating new provisions; amending ORS 243.129, 243.867,
3 411.400, 413.011, 413.017, 741.001, 741.002, 741.029, 741.101, 741.220, 741.300, 741.310, 741.381,
4 741.500, 743.730, 743.733, 743.822 and 743.826; repealing ORS 741.400; and declaring an emer-
5 gency.

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

7 **SECTION 1.** ORS 741.001 is amended to read:

8 741.001. (1) The Oregon Health Insurance Exchange Corporation is established as a public cor-
9 poration performing governmental functions and exercising governmental powers. The corporation
10 shall exercise and carry out statewide all the powers, rights and privileges that are expressly con-
11 ferred upon the corporation, are implied by law or are incident to such powers. Nothing in this
12 section or ORS 741.002 or 741.310 is intended to affect the regulatory responsibilities of the De-
13 partment of Consumer and Business Services under the Insurance Code.

14 (2) The mission of the corporation is to:

15 (a) Incorporate the goals of improving the lifelong health of all Oregonians, increasing the
16 quality, reliability and availability of health insurance for all Oregonians and lowering or containing
17 the cost of health insurance so that health insurance is affordable to everyone.

18 [*(b) Administer a health insurance exchange in the public interest for the benefit of the people and*
19 *businesses that obtain health insurance coverage for themselves, their families and their employees*
20 *through the exchange.*]

21 [*(c)*] **(b)** Empower Oregonians by giving them the information and tools they need to make health
22 insurance choices that meet their needs and values.

23 [*(d)*] **(c)** Improve health care quality and public health, mitigate health disparities linked to race,
24 ethnicity, primary language and similar factors, control costs and ensure access to affordable, equi-
25 table and high-quality health care throughout this state.

26 [*(e)*] **(d)** Be accountable to the public.

27 [*(f)*] **(e)** Encourage the development of new health insurance products that offer innovative:

28 (A) Benefit packages for the coverage of health care services;

29 (B) Health care delivery systems; and

30 (C) Payment mechanisms.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.
New sections are in **boldfaced** type.

1 **SECTION 2.** ORS 741.002 is amended to read:
2 741.002. (1) The duties of the Oregon Health Insurance Exchange Corporation are to:
3 [*(a) Administer a health insurance exchange in accordance with federal law to make qualified*
4 *health plans available to individuals and groups throughout this state.*]
5 [*(b) Provide information in writing, through an Internet-based clearinghouse and through a toll-free*
6 *telephone line that will assist individuals and small businesses in making informed health insurance*
7 *decisions, including:*]
8 [*(A) The grade of each health plan as determined by the corporation and the grading criteria that*
9 *were used;*]
10 [*(B) Quality and enrollee satisfaction ratings; and*]
11 [*(C) The comparative costs, benefits, provider networks of health plans and other useful informa-*
12 *tion.*]
13 [*(c) Establish and make available an electronic calculator that allows individuals and employers*
14 *to determine the cost of coverage after deducting any applicable tax credits or cost-sharing reduction.*]
15 **(a) Ensure that individuals and groups throughout this state can access qualified health**
16 **plans through a health insurance exchange.**
17 [*(d)*] **(b)** Using procedures approved by the corporation's board of directors and adopted by rule
18 by the corporation under ORS 741.310, screen, certify and recertify health plans as qualified health
19 plans according to federal and state standards**,** [*and ensure*] **ensuring** that qualified health plans
20 provide choices of coverage**, and notify the federal government of the certification determi-**
21 **nation**.
22 [*(e)*] **(c)** [*Decertify or suspend, in accordance with ORS chapter 183,*] **Recommend to the federal**
23 **government the decertification or suspension of** the certification of health plans that fail to meet
24 federal and state standards in order to exclude [*them*] **these health plans** from participation in the
25 exchange.
26 [*(f) Promote fair competition of carriers participating in the exchange by certifying multiple health*
27 *plans as qualified under ORS 741.310.*]
28 [*(g)*] **(d)** Grade health plans in accordance with criteria established by the United States Secre-
29 tary of Health and Human Services and by the corporation.
30 [*(h)*] **(e)** Establish open and special enrollment periods for all enrollees, and monthly enrollment
31 periods for Native Americans in accordance with federal law.
32 [*(i)*] **(f)** Assist individuals and groups to enroll in qualified health plans, including defined con-
33 tribution plans as defined in section 414 of the Internal Revenue Code [*and, if appropriate, collect*
34 *and remit premiums for such individuals or groups*].
35 [*(j)*] **(g)** Facilitate community-based assistance with enrollment in qualified health plans by
36 awarding grants to entities that are certified as navigators as described in 42 U.S.C. 18031(i).
37 [*(k) Provide information to individuals and employers regarding the eligibility requirements for*
38 *state medical assistance programs and assist eligible individuals and families in applying for and en-*
39 *rolling in the programs.*]
40 [*(L) Provide employers with the names of employees who end coverage under a qualified health*
41 *plan during a plan year.*]
42 [*(m) Certify the eligibility of an individual for an exemption from the individual responsibility re-*
43 *quirement of section 5000A of the Internal Revenue Code.*]
44 [*(n) Provide information to the federal government necessary for individuals who are enrolled in*
45 *qualified health plans through the exchange to receive tax credits and reduced cost-sharing.*]

[*(o) Provide to the federal government:*]

[*(A) Information regarding individuals determined to be exempt from the individual responsibility requirement of section 5000A of the Internal Revenue Code;*]

[*(B) Information regarding employees who have reported a change in employer;*]

[*(C) Information regarding individuals who have ended coverage during a plan year; and*]

[*(D) Any other information necessary to comply with federal requirements.*]

[*(p)*] **(h)** Take any other actions necessary and appropriate to comply with the federal requirements for a health insurance exchange.

[*(q)*] **(i)** Work in coordination with the Oregon Health Authority, the Oregon Health Policy Board and the Department of Consumer and Business Services in carrying out [*its*] **the corporation's** duties.

(2) The corporation may sue and be sued.

(3) The corporation may:

(a) Acquire, lease, rent, own and manage real property.

(b) Construct, equip and furnish buildings or other structures as are necessary to accommodate the needs of the corporation.

(c) Purchase, rent, lease or otherwise acquire for the corporation's use all supplies, materials, equipment and services necessary to carry out the corporation's duties.

(d) Sell or otherwise dispose of any property acquired under this subsection.

(e) Borrow money and give guarantees to finance its facilities and operations.

(4) Any real property acquired and owned by the corporation under this section shall be subject to ad valorem taxation.

(5) The corporation may not borrow money or give guarantees under subsection (3)(e) of this section unless the obligations of the corporation are payable solely out of the corporation's own resources and do not constitute a pledge of the full faith and credit of the State of Oregon or any of the revenues of this state. The State Treasurer and the State of Oregon may not pay bond-related costs for an obligation incurred by the corporation. A holder of an obligation incurred by the corporation does not have the right to compel the exercise of the taxing power of the state to pay bond-related costs.

(6) The corporation may adopt rules necessary to carry out its mission, duties and functions.

SECTION 3. ORS 741.029 is amended to read:

741.029. (1) The Oregon Health Insurance Exchange Corporation board of directors shall establish an Individual and Employer Consumer Advisory Committee for the purpose of facilitating input from a variety of stakeholders on issues related to the duties of the corporation, the operation of the health insurance exchange and related issues. The board shall determine the membership, terms and organization of the committee and shall appoint the members. Members of the committee shall be representative of:

(a) Individuals and employers that purchase health plans through the exchange;

[*(b) Individuals who enroll in state medical assistance through the exchange;*]

[*(c)*] **(b)** Racial and ethnic minorities in this state;

[*(d)*] **(c)** All geographic regions of this state; and

[*(e)*] **(d)** Organizations that help individuals to enroll in health plans through the exchange, including insurance producers and advocates for hard-to-reach populations.

(2) Members of the committee who are not members of the board are not entitled to compensation, but at the discretion of the board may be reimbursed from funds available to the board for

actual and necessary travel and other expenses incurred by them in the performance of their official duties, in the manner and amount provided in ORS 292.495.

SECTION 4. ORS 741.101 is amended to read:

741.101. (1) As used in this section, "depository" has the meaning given that term in ORS 295.001.

(2) The Oregon Health Insurance Exchange Corporation shall establish one or more accounts in one or more depositories insured by the Federal Deposit Insurance Corporation or the National Credit Union Share Insurance Fund. In a manner consistent with the requirements of ORS 295.001 to 295.108, the corporation shall ensure that sufficient collateral secures any amount of funds on deposit that exceeds the limits of the coverage of the Federal Deposit Insurance Corporation or the National Credit Union Share Insurance Fund. All moneys collected or received by the corporation or placed to the credit of the corporation that are not invested under ORS 741.105 must be deposited to the accounts established under this section, including, but not limited to, moneys received by the corporation through [*premiums or*] the imposition of fees under ORS 741.105 and moneys received as grants under ORS 741.310.

SECTION 5. ORS 741.220 is amended to read:

741.220. (1) The Oregon Health Insurance Exchange Corporation shall keep an accurate accounting of the operation and all activities, receipts and expenditures of the corporation [*and the health insurance exchange*].

(2) [*Beginning after the first 12 months of the operation of the exchange and every 12 months thereafter,*] The Secretary of State **annually** shall conduct a financial audit of the corporation and the accounts established under ORS 741.101 pursuant to ORS 297.210, which shall include but is not limited to:

(a) A review of the sources and uses of the moneys in the accounts; **and**

(b) A review of charges and fees imposed and collected pursuant to ORS 741.105**.**[*; and*]

[*(c) A review of premiums collected and remitted.*]

(3) [*Beginning after the first 24 months of the operation of the exchange and every two years thereafter,*] The Secretary of State **biennially** shall conduct a performance audit of the corporation [*and the exchange*].

(4) The corporation board of directors, the executive director of the corporation and employees of the corporation shall cooperate with the Secretary of State in the audits and reviews conducted under subsections (2) and (3) of this section.

(5) The audits shall be conducted using generally accepted accounting principles and any financial integrity requirements of federal authorities.

(6) The cost of the audits required by subsections (2) and (3) of this section shall be paid by the corporation.

(7) The Secretary of State shall issue a report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Oregon Health Authority, the Oregon Health Policy Board, the Department of Consumer and Business Services and appropriate federal authorities on the results of each audit conducted pursuant to this section, including any recommendations for corrective actions. The report shall be available for public inspection, in accordance with the Secretary of State's established rules and procedures governing public disclosure of audit documents.

(8) To the extent the audit requirements under this section are similar to any audit requirements imposed on the corporation by federal authorities, the Secretary of State and the corporation shall make reasonable efforts to coordinate with the federal authorities to promote efficiency and the best

use of resources in the timing and provision of information.

(9) Not later than the 90th day after the Secretary of State completes and delivers an audit report issued under subsection (7) of this section, the corporation shall notify the Secretary of State in writing of the corrective actions taken or to be taken, if any, in response to any recommendations in the report. The Secretary of State may extend the 90-day period for good cause.

SECTION 6. ORS 741.300 is amended to read:

741.300. As used in ORS 741.001 to 741.540:

(1) "Essential health benefits" has the meaning given that term in ORS 731.097.

(2) "Health care service contractor" has the meaning given that term in ORS 750.005.

(3) "Health insurance" has the meaning given that term in ORS 731.162, excluding disability income insurance.

(4) "Health insurance exchange" or "exchange" means an American Health Benefit Exchange as described in 42 U.S.C. 18031, 18032, 18033 and 18041 [*that is operated by the Oregon Health Insurance Exchange Corporation*].

(5) "Health plan" means health insurance or health care coverage offered by an insurer.

(6) "Insurer" means an insurer as defined in ORS 731.106 that offers health insurance, a health care service contractor or a prepaid managed care health services organization.

(7) "Insurance producer" has the meaning given that term in ORS 731.104.

(8) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.736.

(9) "State program" means [*a program providing medical assistance, as defined in ORS 414.025, and*] any health plan offered through the Public Employees' Benefit Board or the Oregon Educators Benefit Board.

SECTION 7. ORS 741.310 is amended to read:

741.310. (1) The following individuals and groups may purchase qualified health plans through the health insurance exchange:

(a) Beginning January 1, 2014**,**[*:*]

[*(A)*] individuals and families**.**[*; and*]

[*(B) Employers with no more than 50 employees.*]

(b) Beginning October 1, 2015, districts and eligible employees of districts that are subject to ORS 243.886, unless their participation is precluded by federal law.

(c) Beginning January 1, 2016, employers with [*51 to*] **no more than** 100 employees.

(2)(a) Only individuals who purchase health plans through the exchange may be eligible to receive premium tax credits under section 36B of the Internal Revenue Code and reduced cost-sharing under 42 U.S.C. 18071.

(b) Only employers that purchase health plans through the exchange may be eligible to receive small employer health insurance credits under section 45R of the Internal Revenue Code.

(3) Only an insurer that has a certificate of authority to transact insurance in this state and that meets applicable federal requirements for participating in the exchange may offer a qualified health plan through the exchange. Any qualified health plan must be certified under subsection (4) of this section. Prepaid managed care health services organizations that do not have a certificate of authority to transact insurance [*may serve only medical assistance recipients through the exchange and*] may not offer qualified health plans.

(4)[*(a)*] The Oregon Health Insurance Exchange Corporation shall adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans, including require-

ments that a qualified health plan provide, at a minimum, essential health benefits and have acceptable consumer and provider satisfaction ratings.

[*(b) The corporation may limit the number of qualified health plans that may be offered through the exchange as long as the same limit applies to all insurers.*]

[*(5) Notwithstanding subsection (4) of this section, the corporation shall certify as qualified a dental only health plan as permitted by federal law.*]

[*(6)*] **(5)** The corporation shall establish one streamlined and seamless application and enrollment process for both the exchange and the state medical assistance program.

[*(7)*] **(6)** The corporation, in collaboration with the appropriate state authorities, may establish risk mediation programs within the exchange.

[*(8) The corporation shall establish by rule a process for certifying insurance producers to facilitate the transaction of insurance through the exchange, in accordance with federal standards and policies.*]

[*(9)*] **(7)** The corporation shall ensure, as required by federal laws, that an insurer charges the same premiums for plans sold through the exchange as for identical plans sold outside of the exchange.

[*(10)*] **(8)** The corporation is authorized to enter into contracts for the performance of duties, functions or operations of the exchange, including but not limited to contracting with[*:*]

[*(a) All insurers that meet the requirements of subsections (3) and (4) of this section, to offer qualified health plans through the exchange; and*]

[*(b)*] navigators certified by the corporation under ORS 741.002.

[*(11)(a)*] **(9)(a)** The corporation shall consult with stakeholders, including but not limited to representatives of school administrators, school board members, school employees and the Oregon Educators Benefit Board, regarding the plans that may be offered through the exchange to districts and eligible employees of districts under subsection (1)(b) of this section and the insurers that may offer the plans.

(b) The board and the corporation shall each adopt rules to ensure that:

(A) Any plan offered under subsection (1)(b) of this section is underwritten by an insurer using a single risk pool composed of all eligible employees who are enrolled or who will be enrolled in the plan both through the exchange and by the board; and

(B) In every plan offered under subsection (1)(b) of this section, the coverage is comparable to plans offered by the board.

[*(12)*] **(10)** The corporation is authorized to apply for and accept federal grants, other federal funds and grants from nongovernmental organizations for purposes of developing, implementing and administering the exchange. Moneys received under this subsection shall be deposited in an account established under ORS 741.101.

SECTION 8. ORS 741.310, as amended by section 12, chapter 415, Oregon Laws 2011, section 11, chapter 38, Oregon Laws 2012, section 97, chapter 107, Oregon Laws 2012, and section 2, chapter 421, Oregon Laws 2013, is amended to read:

741.310. (1) The following individuals and groups may purchase qualified health plans through the health insurance exchange:

(a) Individuals and families;

(b) Employers with no more than 100 employees; and

(c) Districts and eligible employees of districts that are subject to ORS 243.886, unless their participation is precluded by federal law.

(2)(a) Only individuals who purchase health plans through the exchange may be eligible to receive premium tax credits under section 36B of the Internal Revenue Code and reduced cost-sharing under 42 U.S.C. 18071.

(b) Only employers that purchase health plans through the exchange may be eligible to receive small employer health insurance credits under section 45R of the Internal Revenue Code.

(3) Only an insurer that has a certificate of authority to transact insurance in this state and that meets applicable federal requirements for participating in the exchange may offer a qualified health plan through the exchange. Any qualified health plan must be certified under subsection (4) of this section. Prepaid managed care health services organizations that do not have a certificate of authority to transact insurance [*may serve only medical assistance recipients through the exchange and*] may not offer qualified health plans.

(4)[*(a)*] The Oregon Health Insurance Exchange Corporation shall adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans, including requirements that a qualified health plan provide, at a minimum, essential health benefits and have acceptable consumer and provider satisfaction ratings.

[*(b) The corporation may limit the number of qualified health plans that may be offered through the exchange as long as the same limit applies to all insurers.*]

[*(5) Notwithstanding subsection (4) of this section, the corporation shall certify as qualified a dental only health plan as permitted by federal law.*]

[*(6)*] **(5)** The corporation shall establish one streamlined and seamless application and enrollment process for both the exchange and the state medical assistance program.

[*(7)*] **(6)** The corporation, in collaboration with the appropriate state authorities, may establish risk mediation programs within the exchange.

[*(8) The corporation shall establish by rule a process for certifying insurance producers to facilitate the transaction of insurance through the exchange, in accordance with federal standards and policies.*]

[*(9)*] **(7)** The corporation shall ensure, as required by federal laws, that an insurer charges the same premiums for plans sold through the exchange as for identical plans sold outside of the exchange.

[*(10)*] **(8)** The corporation is authorized to enter into contracts for the performance of duties, functions or operations of the exchange, including but not limited to contracting with[*:*]

[*(a) Insurers that meet the requirements of subsections (3) and (4) of this section, to offer qualified health plans through the exchange; and*]

[*(b)*] navigators certified by the corporation under ORS 741.002.

[*(11)(a)*] **(9)(a)** The corporation shall consult with stakeholders, including but not limited to representatives of school administrators, school board members, school employees and the Oregon Educators Benefit Board, regarding the plans that may be offered through the exchange to districts and eligible employees of districts under subsection (1)(c) of this section and the insurers that may offer the plans.

(b) The board and the corporation shall each adopt rules to ensure that:

(A) Any plan offered under subsection (1)(c) of this section is underwritten by an insurer using a single risk pool composed of all eligible employees who are enrolled or who will be enrolled in the plan both through the exchange and by the board; and

(B) In every plan offered under subsection (1)(c) of this section, the coverage is comparable to plans offered by the board.

[*(12)*] **(10)** The corporation is authorized to apply for and accept federal grants, other federal funds and grants from nongovernmental organizations for purposes of developing, implementing and administering the exchange. Moneys received under this subsection shall be deposited in an account established under ORS 741.101.

SECTION 9. ORS 741.381 is amended to read:

741.381. The activities of insurers working under the direction of the Oregon Health Authority, the Oregon Health Insurance Exchange Corporation and the Department of Consumer and Business Services pursuant to ORS 413.011 (1)(j) or participating in the health insurance exchange [*administered under*] **described in** ORS 741.002 do not constitute a conspiracy or restraint of trade or an illegal monopoly, nor are they carried out for the purposes of lessening competition or fixing prices arbitrarily.

SECTION 10. ORS 741.500 is amended to read:

741.500. [*(1)(a) The Oregon Health Insurance Exchange Corporation shall adopt by rule the information that must be documented in order for a person to qualify for:*]

[*(A) Health plan coverage through the health insurance exchange;*]

[*(B) Premium tax credits; and*]

[*(C) Cost-sharing reductions.*]

[*(b) The documentation specified by the corporation under this subsection shall include but is not limited to documentation of:*]

[*(A) The identity of the person;*]

[*(B) The status of the person as a United States citizen, or lawfully admitted noncitizen, and a resident of this state;*]

[*(C) Information concerning the income and resources of the person as necessary to establish the person's financial eligibility for coverage, for premium tax credits and for cost-sharing reductions, which may include income tax return information and a Social Security number; and*]

[*(D) Employer identification information and employer-sponsored health insurance coverage information applicable to the person.*]

[*(2) The corporation shall adopt by rule the information that must be documented in order to determine whether the person is exempt from a requirement to purchase or be enrolled in a health plan under section 5000A of the Internal Revenue Code or other federal law.*]

[*(3)*] **(1)** The **Oregon Health Insurance Exchange** Corporation shall implement systems that provide electronic access to, and use, disclosure and validation of data needed to administer the duties, functions and operation of the corporation, to comply with federal data access and data exchange requirements and to streamline and simplify processes of the corporation.

[*(4)*] **(2)** Information and data that the corporation obtains under this section may be exchanged with other state or federal health insurance exchanges, with state or federal agencies and, subject to ORS 741.510, for the purpose of carrying out exchange responsibilities**.**[*, including but not limited to:*]

[*(a) Establishing and verifying eligibility for:*]

[*(A) A state medical assistance program;*]

[*(B) The purchase of health plans through the exchange; and*]

[*(C) Any other programs that are offered through the exchange;*]

[*(b) Establishing and verifying the amount of a person's federal tax credit, cost-sharing reduction or premium assistance;*]

[*(c) Establishing and verifying eligibility for exemption from the requirement to purchase or be*

enrolled in a health plan under section 5000A of the Internal Revenue Code or other federal law;]

[*(d) Complying with other federal requirements; or*]

[*(e) Improving the operations of the exchange and other programs administered by the corporation and for program analysis.*]

SECTION 11. ORS 743.730 is amended to read:

743.730. For purposes of ORS 743.730 to 743.773:

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) Has a constitution and bylaws; and

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

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

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

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

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

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by

1 ORS 743.733 to 743.737; or
2 (e) Any other person or corporation responsible for the payment of benefits or provision of ser-
3 vices.
4 [*(6) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic*
5 *plan under 42 U.S.C. 18022(e) and that is offered through the Oregon health insurance exchange.*]
6 [*(7)*] **(6)** "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg
7 as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time
8 the enrollee obtains new coverage.
9 [*(8)*] **(7)** "Dependent" means the spouse or child of an eligible employee, subject to applicable
10 terms of the health benefit plan covering the employee.
11 [*(9)*] **(8)** "Eligible employee" means an employee who works on a regularly scheduled basis, with
12 a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility
13 between 17.5 and 40 hours per week subject to rules of the carrier. "Eligible employee" does not
14 include employees who work on a temporary, seasonal or substitute basis. Employees who have been
15 employed by the employer for fewer than 90 days are not eligible employees unless the employer so
16 allows.
17 [*(10)*] **(9)** "Employee" means any individual employed by an employer.
18 [*(11)*] **(10)** "Enrollee" means an employee, dependent of the employee or an individual otherwise
19 eligible for a group or individual health benefit plan who has enrolled for coverage under the terms
20 of the plan.
21 [*(12)*] **(11)** "Exchange" means the health insurance exchange [*administered by the Oregon Health*
22 *Insurance Exchange Corporation in accordance with*] **described in** ORS 741.310.
23 [*(13)*] **(12)** "Exclusion period" means a period during which specified treatments or services are
24 excluded from coverage.
25 [*(14)*] **(13)** "Financial impairment" means that a carrier is not insolvent and is:
26 (a) Considered by the director to be potentially unable to fulfill its contractual obligations; or
27 (b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.
28 [*(15)(a)*] **(14)(a)** "Geographic average rate" means the arithmetical average of the lowest pre-
29 mium and the corresponding highest premium to be charged by a carrier in a geographic area es-
30 tablished by the director for the carrier's:
31 (A) Group health benefit plans offered to small employers; or
32 (B) Individual health benefit plans.
33 (b) "Geographic average rate" does not include premium differences that are due to differences
34 in benefit design, age, tobacco use or family composition.
35 [*(16)*] **(15)** "Grandfathered health plan" has the meaning prescribed by the United States Secre-
36 taries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).
37 [*(17)*] **(16)** "Group eligibility waiting period" means, with respect to a group health benefit plan,
38 the period of employment or membership with the group that a prospective enrollee must complete
39 before plan coverage begins.
40 [*(18)(a)*] **(17)(a)** "Health benefit plan" means any:
41 (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;
42 (B) Health care service contractor or health maintenance organization subscriber contract; or
43 (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-
44 ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the
45 extent that the plan is subject to state regulation.

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

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

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

(C) Medicare supplement insurance policies;

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

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

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

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

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

(I) Dental only coverage;

(J) Vision only coverage;

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

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

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

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

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

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

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

[*(20)*] **(19)** "Individual health benefit plan" means a health benefit plan:

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

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

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

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

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

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

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

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

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

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

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

[*(25)*] **(24)** "Preexisting condition exclusion" means:

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

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

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

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

[*(28)*] **(27)** "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

[*(29)(a)*] **(28)(a)** "Small employer" means an employer that employed an average of at least one but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least one eligible employee on the first day of the plan year.

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

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

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

743.730. For purposes of ORS 743.730 to 743.773:

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

and methods used by the carrier in establishing premium rates for small employer health benefit plans.

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

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

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

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

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

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

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

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

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

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

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

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

(f) Has a constitution and bylaws; and

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

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

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

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

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

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

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

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

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

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

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

[*(10)*] **(9)** "Employee" means any individual employed by an employer.

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

[*(12)*] **(11)** "Exchange" means the health insurance exchange [*administered by the Oregon Health Insurance Exchange Corporation in accordance with*] **described in** ORS 741.310.

[*(13)*] **(12)** "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

[*(14)*] **(13)** "Financial impairment" means that a carrier is not insolvent and is:

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

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

[*(15)(a)*] **(14)(a)** "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

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

(B) Individual health benefit plans.

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

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

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

[*(18)(a)*] **(17)(a)** "Health benefit plan" means any:

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

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

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

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

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

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

(C) Medicare supplement insurance policies;

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

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

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

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

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

(I) Dental only coverage;

(J) Vision only coverage;

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

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

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

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

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

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

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

[*(20)*] **(19)** "Individual health benefit plan" means a health benefit plan:

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

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

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

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

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

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

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

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

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

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

[*(24)*] **(23)** "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974,

as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

[*(25)*] **(24)** "Preexisting condition exclusion" means:

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

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

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

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

[*(28)*] **(27)** "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

[*(29)(a)*] **(28)** "Small employer" means an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least one eligible employee on the first day of the plan year.

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

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

SECTION 13. ORS 743.733 is amended to read:

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

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

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

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

SECTION 14. ORS 743.822 is amended to read:

743.822. (1) In each individual or small group market, in which a carrier offers a health benefit

plan through or outside of the [*Oregon*] health insurance exchange **described in ORS 741.310**, the carrier must offer to residents of this state a bronze and a silver plan approved by the Department of Consumer and Business Services as meeting the requirements of subsection (2) of this section.

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

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

SECTION 15. ORS 743.826 is amended to read:

743.826. **(1) As used in this section, "catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered only through the health insurance exchange described in ORS 741.310.**

(2) A carrier may offer a catastrophic plan [*only through the exchange and*] only to an individual who:

[*(1)*] **(a)** Is under 30 years of age at the beginning of the plan year; or

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

SECTION 16. ORS 243.129 is amended to read:

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

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

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

(a) The alternative benefit plan is offered through the health insurance exchange under ORS 741.310 [*(1)(b)*]; and

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

SECTION 17. ORS 243.867 is amended to read:

243.867. (1) The governing body of a local government may elect to participate in a benefit plan offered by the Oregon Educators Benefit Board.

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

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

(a) The alternative benefit plan is offered through the health insurance exchange under ORS 741.310 [*(1)(b)*]; and

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

SECTION 18. ORS 411.400 is amended to read:

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

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

(a) Over the Internet;

(b) By telephone;

(c) By mail;

(d) In person; and

(e) Through other commonly available electronic means.

(3) The department and the authority may require an applicant or person acting on behalf of an applicant to provide only the information necessary for the purpose of making an eligibility determination or for a purpose directly connected to the administration of medical assistance or the health insurance exchange.

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

(a) Over the Internet;

(b) By telephone; and

(c) In person.

[*(5)(a) The department and the authority shall promptly transfer information received under this section to the Oregon Health Insurance Exchange Corporation as necessary for the corporation to determine eligibility for the exchange, premium tax credits or cost-sharing reductions.*]

[*(b)*] **(5)** The department shall promptly transfer information received under this section to the authority for individuals who are eligible for medical assistance because they qualify for public assistance.

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

SECTION 19. ORS 413.011 is amended to read:

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

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

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

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

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

(e) Establish evidence-based clinical standards and practice guidelines that may be used by providers.

(f) Approve and monitor community-centered health initiatives described in ORS 413.032 (1)(h) that are consistent with public health goals, strategies, programs and performance standards

adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and shall regularly report to the Legislative Assembly on the accomplishments and needed changes to the initiatives.

(g) Establish cost containment mechanisms to reduce health care costs.

(h) Ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by the expansion in health coverage, health care system transformations, an increasingly diverse population and an aging workforce.

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

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

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

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

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

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

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

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

(n) Work with the Public Health Benefit Purchasers Committee, administrators of the medical assistance program and the Department of Corrections to identify uniform contracting standards for health benefit plans that achieve maximum quality and cost outcomes and align the contracting standards for all state programs to the greatest extent practicable.

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

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

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

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

(4) The enumeration of duties, functions and powers in this section is not intended to be exclu-

sive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042 and 741.340 and by other statutes.

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

SECTION 20. ORS 413.017 is amended to read:

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

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

(A) The Public Employees' Benefit Board.

(B) The Oregon Educators Benefit Board.

(C) Trustees of the Public Employees Retirement System.

(D) A city government.

(E) A county government.

(F) A special district.

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

(b) The Public Health Benefit Purchasers Committee shall:

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

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

(C) Continuously review and report to the Oregon Health Policy Board on the committee's progress in aligning benefits while minimizing the cost shift to individual purchasers of insurance without shifting costs to the private sector or the [*Oregon*] health insurance exchange.

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

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

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

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

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

1 needs of Oregonians for health care.
2 (4) Members of the committees described in subsections (2) and (3) of this section who are not
3 members of the Oregon Health Policy Board are not entitled to compensation but shall be reim-
4 bursed from funds available to the board for actual and necessary travel and other expenses in-
5 curred by them by their attendance at committee meetings, in the manner and amount provided in
6 ORS 292.495.
7 **SECTION 21.** ORS 741.300, as amended by section 6 of this 2015 Act, is amended to read:
8 741.300. As used in ORS 741.001 to 741.540:
9 (1) "Essential health benefits" has the meaning given that term in ORS 731.097.
10 (2) "Health care service contractor" has the meaning given that term in ORS 750.005.
11 (3) "Health insurance" has the meaning given that term in ORS 731.162, excluding disability
12 income insurance.
13 (4) "Health insurance exchange" or "exchange" means an American Health Benefit Exchange
14 as described in 42 U.S.C. 18031, 18032, 18033 and 18041.
15 (5) "Health plan" means health insurance or health care coverage offered by an insurer.
16 (6) "Insurer" means an insurer as defined in ORS 731.106 that offers health insurance, a health
17 care service contractor or a prepaid managed care health services organization.
18 (7) "Insurance producer" has the meaning given that term in ORS 731.104.
19 [*(8) "Prepaid managed care health services organization" has the meaning given that term in ORS*
20 *414.736.*]
21 [*(9)*] **(8)** "State program" means any health plan offered through the Public Employees' Benefit
22 Board or the Oregon Educators Benefit Board.
23 **SECTION 22. The amendments to ORS 741.300 by section 21 of this 2015 Act become op-**
24 **erative on July 1, 2017.**
25 **SECTION 23. ORS 741.400 is repealed.**
26 **SECTION 24. This 2015 Act being necessary for the immediate preservation of the public**
27 **peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect**
28 **on its passage.**
29