House Bill 2302

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of House Interim Committee on Health Care for Capital Dental Care)

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 definition of "prepaid managed care health services organization."
Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care; amending ORS 192.493, 192.579, 414.736, 416.510, 741.300, 741.310, 743.061 and 743.847; repealing ORS 414.727; and declaring an emergency.

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

SECTION 1. ORS 192.493 is amended to read:

192.493. A record of an agency of the executive department as defined in ORS 174.112 that contains the following information is a public record subject to inspection under ORS 192.420 and is not exempt from disclosure under ORS 192.501 or 192.502 except to the extent that the record discloses information about an individual's health or is proprietary to a person:

(1) The amounts determined by an independent actuary retained by the agency to cover the costs of providing each of the following health services under ORS 414.631, 414.651 and 414.688 to 414.745 for the six months preceding the report:

(a) Inpatient hospital services;

(b) Outpatient hospital services;

(c) Laboratory and X-ray services;

(d) Physician and other licensed practitioner services;

(e) Prescription drugs;

(f) Dental services;

(g) Vision services;

(h) Mental health services;

(i) Chemical dependency services;

(j) Durable medical equipment and supplies; and

(k) Other health services provided under a coordinated care organization contract under ORS 414.651 or a contract with a prepaid managed care health services organization**, as defined in ORS 416.510**;

(2) The amounts the agency and each contractor have paid under each coordinated care organization contract under ORS 414.651 or prepaid managed care health services organization contract for administrative costs and the provision of each of the health services described in subsection (1) of this section for the six months preceding the report;

(3) Any adjustments made to the amounts reported under this section to account for geographic or other differences in providing the health services; and

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.

(4) The numbers of individuals served under each coordinated care organization contract or prepaid managed care health services organization contract, listed by category of individual.

SECTION 2. ORS 192.579 is amended to read:

192.579. (1) As used in this section, "entity" means a [*health care provider or a prepaid managed care health services organization, as defined in ORS 414.736, that provides health care to an individual, if the care is paid for by a state health plan*] **person who is reimbursed through the state medical assistance program for providing care to a recipient of medical assistance**.

(2) Notwithstanding ORS 179.505, an entity may disclose the identity of an individual who receives health care from the entity without obtaining an authorization from the individual, or a personal representative of the individual, to another entity for the purpose of coordinating the health care and treatment provided to the individual by either entity.

SECTION 3. ORS 414.736 is amended to read:

414.736. As used in [*ORS 192.493,*] this chapter[*, ORS chapter 416*] and section 9, chapter 867, Oregon Laws 2009:

(1) "Designated area" means a geographic area of the state defined by the Oregon Health Authority by rule that is served by a prepaid managed care health services organization.

(2) "Fully capitated health plan" means an organization that contracts with the authority on a prepaid capitated basis under ORS 414.618.

(3) "Physician care organization" means an organization that contracts with the authority on a prepaid capitated basis under ORS 414.618 to provide the health services described in ORS 414.025 (7)(b), (c), (d), (e), (f), (g) and (j). A physician care organization may also contract with the authority on a prepaid capitated basis to provide the health services described in ORS 414.025 (7)(k) and (L).

(4) "Prepaid managed care health services organization" means a managed physical health, dental, mental health or chemical dependency organization that contracts with the authority on a prepaid capitated basis under ORS 414.618. A prepaid managed care health services organization may be a dental care organization, fully capitated health plan, physician care organization, mental health organization or chemical dependency organization.

SECTION 4. ORS 416.510 is amended to read:

416.510. As used in ORS 416.510 to 416.610, unless the context requires otherwise:

(1) "Action" means an action, suit or proceeding.

(2) "Alternative payment methodology" has the meaning given that term in ORS 414.025.

(3) "Applicant" means an applicant for assistance.

(4) "Assistance" means moneys paid by the Department of Human Services to persons directly and moneys paid by the Oregon Health Authority or by a prepaid managed care health services organization or a coordinated care organization for services provided under contract pursuant to ORS 414.651 to others for the benefit of such persons.

(5) "Authority" means the Oregon Health Authority.

(6) "Claim" means a claim of a recipient of assistance for damages for personal injuries against any person or public body, agency or commission other than the State Accident Insurance Fund Corporation or Workers' Compensation Board.

(7) "Compromise" means a compromise between a recipient and any person or public body, agency or commission against whom the recipient has a claim.

(8) "Coordinated care organization" means an organization that meets the criteria adopted by the authority under ORS 414.625.

(9) "Judgment" means a judgment in any action or proceeding brought by a recipient to enforce

the claim of the recipient.

(10) "Prepaid managed care health services organization" means a managed health, dental or mental health care organization that contracted with the authority**, or with a coordinated care organization,** on a prepaid capitated basis. Prepaid managed care health services organizations may be dental care organizations, fully capitated health plans, mental health organizations or chemical dependency organizations.

(11) "Recipient" means a recipient of assistance.

(12) "Settlement" means a settlement between a recipient and any person or public body, agency or commission against whom the recipient has a claim.

SECTION 5. ORS 741.300 is amended to read:

741.300. As used in ORS 741.001 to 741.540:

(1) "Coordinated care organization" has the meaning given that term in ORS 414.025.

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

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

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

[*(4)*] **(5)** "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)*] **(6)** "Health plan" means health insurance or health care coverage offered by an insurer.

[*(6)*] **(7)** "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 **or a coordinated care organization**.

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

[*(8)*] **(9)** "Prepaid managed care health services organization" has the meaning given that term in ORS [*414.736*] **416.510**.

[*(9)*] **(10)** "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 6. 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 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 **and coordinated care 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) The corporation shall establish one streamlined and seamless application and enrollment process for both the exchange and the state medical assistance program.

(7) 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) 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) 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) 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) 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 7. 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 **and coordinated care 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) The corporation shall establish one streamlined and seamless application and enrollment process for both the exchange and the state medical assistance program.

(7) 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) 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) 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) 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) 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 743.061 is amended to read:

743.061. (1) The Department of Consumer and Business Services may adopt by rule uniform standards applicable to persons listed in subsection (2) of this section for health care financial and administrative transactions, including uniform standards for:

(a) Eligibility inquiry and response;

(b) Claim submission;

(c) Payment remittance advice;

(d) Claims payment or electronic funds transfer;

(e) Claims status inquiry and response;

(f) Claims attachments;

(g) Prior authorization;

(h) Provider credentialing; or

(i) Health care financial and administrative transactions identified by the stakeholder work group described in ORS 743.062.

(2) Any uniform standards adopted under subsection (1) of this section apply to:

(a) Health insurers.

(b) Prepaid managed care health services organizations as defined in ORS [*414.736*] **416.510**.

(c) Coordinated care organizations as defined in ORS 414.025.

[*(c)*] **(d)** Third party administrators.

[*(d)*] **(e)** Any person or public body that either individually or jointly establishes a self-insurance plan, program or contract, including but not limited to persons and public bodies that are otherwise exempt from the Insurance Code under ORS 731.036.

[*(e)*] **(f)** Health care clearinghouses or other entities that process or facilitate the processing of health care financial and administrative transactions from a nonstandard format to a standard format.

[*(f)*] **(g)** Any other person identified by the department that processes health care financial and administrative transactions between a health care provider and an entity described in this subsection.

(3) In developing or updating any uniform standards adopted under subsection (1) of this section, the department shall consider recommendations from the Oregon Health Authority under ORS 743.062.

SECTION 9. ORS 743.847 is amended to read:

743.847. (1) For the purposes of this section:

(a) "Health insurer" or "insurer" means an employee benefit plan, self-insured plan, managed care organization or group health plan, a third party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service.

(b) "Medicaid" means medical assistance provided under 42 U.S.C. 1396a (section 1902 of the Social Security Act).

(2) A health insurer is prohibited from considering the availability or eligibility for medical assistance in this or any other state under Medicaid when considering eligibility for coverage or making payments under its group or individual plan for eligible enrollees, subscribers, policyholders or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual, in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) An insurer may not deny a claim submitted by the state Medicaid agency, a prepaid managed care health services organization**, as defined in ORS 416.510,** or a coordinated care organization**, as defined in ORS 414.025,** [*described in ORS 414.651*] under subsection (3) of this section based on the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point of sale that is the basis of the claim if:

(a) The claim is submitted by the agency, the prepaid managed care health services organization or the coordinated care organization within the three-year period beginning on the date on which the health care item or service was furnished; and

(b) Any action by the agency, the prepaid managed care health services organization or the coordinated care organization to enforce its rights with respect to the claim is commenced within six years of the agency's or organization's submission of the claim.

(5) An insurer must provide to the state Medicaid agency, a prepaid managed care health services organization or a coordinated care organization, upon request, the following information:

(a) The period during which a Medicaid recipient, the spouse or dependents may be or may have been covered by the plan;

(b) The nature of coverage that is or was provided by the plan; and

(c) The name, address and identifying numbers of the plan.

(6) An insurer may not deny enrollment of a child under the group or individual health plan of the child's parent on the ground that:

(a) The child was born out of wedlock;

(b) The child is not claimed as a dependent on the parent's federal tax return; or

(c) The child does not reside with the child's parent or in the insurer's service area.

(7) When a child has group or individual health coverage through an insurer of a noncustodial parent, the insurer must:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) Make payments on claims submitted in accordance with paragraph (b) of this subsection directly to the custodial parent, the provider or, if a claim is filed by the state Medicaid agency, a prepaid managed care health services organization or a coordinated care organization, directly to the agency or the organization.

(8) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer must:

(a) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for

the coverage without regard to any enrollment season restrictions;

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program; and

(c) Not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

(9) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer if the requirements are different from requirements applicable to an agent or assignee of any other individual so covered.

(10) The provisions of ORS 743A.001 do not apply to this section.

SECTION 10. ORS 414.727 is repealed.

SECTION 11. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.