House Bill 2046

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of Governor Kate Brown for Department of Consumer and Business Services)

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.**

Removes or modifies certain references to federal law in laws concerning health insurance.

A BILL FOR AN ACT

Relating to health insurance; amending ORS 414.025, 731.097, 741.002, 741.004, 741.300, 741.500, 743.826, 743A.067, 743A.262, 743B.005, 743B.013 and 743B.105.

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

SECTION 1. ORS 731.097 is amended to read:

731.097. "Essential health benefits" are the items and services prescribed by the Department of Consumer and Business Services by rule [*in accordance*] **consistent** with federal law, including:

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn care.

(5) Mental health and substance use disorder services, including behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services, including oral and vision care.

SECTION 2. ORS 741.002 is amended to read:

741.002. (1) The duties of the Department of Consumer and Business Services include:

(a) Administering a health insurance exchange [*in accordance with federal law*] to make qualified health plans available to individuals and groups throughout this state.

(b) Providing information in writing, through an Internet-based clearinghouse and through a toll-free telephone line, that will assist individuals and small businesses in making informed health insurance decisions and that may include:

(A) The rating assigned to each health plan and the rating criteria that were used;

(B) Quality and enrollee satisfaction survey results; and

(C) The comparative costs, benefits, provider networks of health plans and other useful information.

(c) Establishing and maintaining an electronic calculator that allows individuals and employers to determine the cost of coverage after deducting any applicable tax credits or cost-sharing reduction.

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.

(d) Operating a call center for answers to questions from individuals seeking enrollment in a qualified health plan or in the state medical assistance program.

(e) Providing information about the eligibility requirements and the application processes for the state medical assistance program.

(2) The department shall:

(a) Screen, certify and recertify health plans as qualified health plans according to the requirements, standards and criteria adopted by the department under ORS 741.310 and ensure that qualified health plans provide choices of coverage.

(b) Decertify or suspend, in accordance with ORS chapter 183, the certification of a health plan that fails to meet federal and state standards in order to exclude the health plan from participation in the exchange.

(c) Promote fair competition of carriers participating in the exchange by certifying multiple health plans as qualified under ORS 741.310.

(d) Assign ratings to health plans in accordance with criteria established by [*the United States Secretary of Health and Human Services and by*] the department.

(e) Establish open and special enrollment periods for all enrollees, and monthly enrollment periods for Native Americans [*in accordance with federal law*].

(f) Assist individuals and groups to enroll in qualified health plans, including defined contribution plans as defined in section 414 of the Internal Revenue Code and, if appropriate, collect and remit premiums for such individuals or groups.

(g) Facilitate community-based assistance with enrollment in qualified health plans by awarding grants to entities that are certified as navigators as described in 42 U.S.C. 18031(i).

(h) Provide employers with the names of employees who end coverage under a qualified health plan during a plan year.

[*(i) Certify the eligibility of an individual for an exemption from the individual responsibility requirement of section 5000A of the Internal Revenue Code.*]

[*(j)*] **(i)** Provide information to the federal government necessary for individuals who are enrolled in qualified health plans through the exchange to receive tax credits and reduced cost-sharing.

[*(k)*] **(j)** Provide to the federal government any information necessary to comply with federal requirements including:

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

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

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

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

[*(m)*] **(L)** Work in coordination with the Oregon Health Authority and the Oregon Health Policy Board in carrying out its duties.

(3) The department may adopt rules necessary to carry out its duties and functions under ORS 741.001 to 741.540.

(4) The department may contract or enter into an intergovernmental agreement with the federal government to perform any of the duties and functions described in ORS 741.001 to 741.540.

(5) The department may assign contracts to the Oregon Health Authority if necessary for the authority to administer the state medical assistance program.

SECTION 3. ORS 741.004 is amended to read:

741.004. (1) The Health Insurance Exchange Advisory Committee is created to advise the Director of the Department of Consumer and Business Services in the development and implementation of the policies and operational procedures governing the administration of a health insurance exchange in this state including, but not limited to, all of the following:

(a) The amount of the assessment imposed on insurers under ORS 741.105.

(b) The implementation of a Small Business Health Options Program [*in accordance with 42 U.S.C. 18031*].

(c) The processes and procedures to enable each insurance producer to be authorized to act for all of the insurers offering health benefit plans through the health insurance exchange.

(d) The affordability of health benefit plans offered by employers [*under section 5000A(e)(1) of the Internal Revenue Code*].

(e) Outreach strategies for reaching minority and low-income communities.

(f) Solicitation of customer feedback.

(g) The affordability of health benefit plans offered through the exchange.

(2) The committee consists of 15 members. Thirteen members shall be appointed by the Governor and are subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565. The appointed members serve at the pleasure of the Governor. The Director of the Department of Consumer and Business Services and the Director of the Oregon Health Authority shall serve as ex officio members of the committee.

(3) The 13 members appointed by the Governor must represent the interests of:

(a) Insurers;

(b) Insurance producers;

(c) Navigators, in-person assisters, application counselors and other individuals with experience in facilitating enrollment in qualified health plans;

(d) Health care providers;

(e) The business community, including small businesses and self-employed individuals;

(f) Consumer advocacy groups, including advocates for enrolling hard-to-reach populations;

(g) Enrollees in health benefit plans; and

(h) State agencies that administer the medical assistance program under ORS chapter 414.

(4) The Director of the Department of Consumer and Business Services may solicit recommendations from the committee and the committee may initiate recommendations on its own.

(5) The committee shall provide annual reports to the Legislative Assembly, in the manner provided in ORS 192.245, of the findings and recommendations the committee considers appropriate, including a report on the:

(a) Adequacy of assessments for reserve programs and administrative costs;

(b) Implementation of the Small Business Health Options Program;

(c) Number of qualified health plans offered through the exchange;

(d) Number and demographics of individuals enrolled in qualified health plans;

(e) Advance premium tax credits provided to enrollees in qualified health plans; and

(f) Feedback from the community about satisfaction with the operation of the exchange and qualified health plans offered through the exchange.

(6) The members of the committee shall be appointed for a term of two years and shall serve without compensation, but shall be entitled to travel expenses in accordance with ORS 292.495. The committee may hire, subject to the approval of the Director of the Department of Consumer and Business Services, such experts as the committee may require to discharge its duties. All expenses

of the committee shall be paid out of the Health Insurance Exchange Fund established in ORS 741.102.

(7) The employees of the Department of Consumer and Business Services are directed to assist the committee in the performance of its duties under subsection (1) of this section and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the committee consider necessary to perform their duties under subsection (1) of this section.

SECTION 4. 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.

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

(3) "Health benefit plan" has the meaning given that term in ORS 743B.005.

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

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

(6) "Health insurance exchange" or "exchange" means [*an American Health Benefit Exchange as described in 42 U.S.C. 18031, 18032, 18033 and 18041*] **the health insurance exchange administered by the Department of Consumer and Business Services in accordance with ORS 741.002**.

(7) "Health plan" means health insurance, a health benefit plan or health care coverage offered by an insurer.

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

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

(10) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025.

(11) "State program" means a program providing medical assistance, as defined in ORS 414.025, and any self-insured health benefit plan or health plan offered to employees by the Public Employees' Benefit Board or the Oregon Educators Benefit Board.

(12) "Qualified health plan" means a health benefit plan available for purchase through the health insurance exchange.

(13) "Small Business Health Options Program" or "SHOP" means a health insurance exchange for small employers [*as described in 42 U.S.C. 18031*].

SECTION 5. ORS 741.500 is amended to read:

741.500. (1)(a) The Department of Consumer and Business Services 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 department 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 department 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)*] **(2)** The department shall implement systems that provide electronic access to, and use, disclosure and validation of data needed to administer the exchange, to comply with federal data access and data exchange requirements and to streamline and simplify exchange processes.

[*(4)*] **(3)** Information and data that the department 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)*] **(c)** Complying with other federal requirements; or

[*(e)*] **(d)** Improving the operations of the exchange and for program analysis.

SECTION 6. ORS 743.826 is amended to read:

743.826. (1) As used in this section**,**[*:*]

[*(a)*] "catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e).

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

(2) A carrier may offer a catastrophic plan only to an individual who:

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

(b) Is exempt from any state or federal penalties imposed for failing to maintain minimum essential coverage**, as defined by the Department of Consumer and Business Services by rule,** during the plan year.

SECTION 7. ORS 743A.067 is amended to read:

743A.067. (1) As used in this section:

(a) "Contraceptives" means health care services, drugs, devices, products or medical procedures to prevent a pregnancy.

(b) "Enrollee" means an insured individual and the individual's spouse, domestic partner and dependents who are beneficiaries under the insured individual's health benefit plan.

(c) "Health benefit plan" has the meaning given that term in ORS 743B.005, excluding Medicare Advantage Plans and including health benefit plans offering pharmacy benefits administered by a third party administrator or pharmacy benefit manager.

(d) "Prior authorization" has the meaning given that term in ORS 743B.001.

(e) "Religious employer" has the meaning given that term in ORS 743A.066.

(f) "Utilization review" has the meaning given that term in ORS 743B.001.

(2) A health benefit plan offered in this state must provide coverage for all of the following services, drugs, devices, products and procedures:

(a) Well-woman care prescribed by the Department of Consumer and Business Services by rule consistent with guidelines published by the United States Health Resources and Services Administration.

(b) Counseling for sexually transmitted infections, including but not limited to human immunodeficiency virus and acquired immune deficiency syndrome.

(c) Screening for:

(A) Chlamydia;

(B) Gonorrhea;

(C) Hepatitis B;

(D) Hepatitis C;

(E) Human immunodeficiency virus and acquired immune deficiency syndrome;

(F) Human papillomavirus;

(G) Syphilis;

(H) Anemia;

(I) Urinary tract infection;

(J) Pregnancy;

(K) Rh incompatibility;

(L) Gestational diabetes;

(M) Osteoporosis;

(N) Breast cancer; and

(O) Cervical cancer.

(d) Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indicated.

(e) Screening and appropriate counseling or interventions for:

(A) Tobacco use; and

(B) Domestic and interpersonal violence.

(f) Folic acid supplements.

(g) Abortion.

(h) Breastfeeding comprehensive support, counseling and supplies.

(i) Breast cancer chemoprevention counseling.

(j) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, subject to all of the following:

(A) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, a health benefit plan may provide coverage for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.

(B) If a contraceptive drug, device or product covered by the health benefit plan is deemed medically inadvisable by the enrollee's provider, the health benefit plan must cover an alternative contraceptive drug, device or product prescribed by the provider.

(C) A health benefit plan must pay pharmacy claims for reimbursement of all contraceptive

drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(D) A health benefit plan may not infringe upon an enrollee's choice of contraceptive drug, device or product and may not require prior authorization, step therapy or other utilization review techniques for medically appropriate covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(k) Voluntary sterilization.

(L) As a single claim or combined with other claims for covered services provided on the same day:

(A) Patient education and counseling on contraception and sterilization.

(B) Services related to sterilization or the administration and monitoring of contraceptive drugs, devices and products, including but not limited to:

(i) Management of side effects;

(ii) Counseling for continued adherence to a prescribed regimen;

(iii) Device insertion and removal; and

(iv) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the enrollee's provider.

(m) Any additional preventive services for women that must be covered without cost sharing under 42 U.S.C. 300gg-13, as identified by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services as of January 1, [*2017*] **2020**.

(3) A health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage required by this section. A health care provider shall be reimbursed for providing the services described in this section without any deduction for coinsurance, copayments or any other cost-sharing amounts.

(4) Except as authorized under this section, a health benefit plan may not impose any restrictions or delays on the coverage required by this section.

(5) This section does not exclude coverage for contraceptive drugs, devices or products prescribed by a provider, acting within the provider's scope of practice, for:

(a) Reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause; or

(b) Contraception that is necessary to preserve the life or health of an enrollee.

(6) This section does not limit the authority of the Department of Consumer and Business Services to ensure compliance with ORS 743A.063 and 743A.066.

(7) This section does not require a health benefit plan to cover:

(a) Experimental or investigational treatments;

(b) Clinical trials or demonstration projects, except as provided in ORS 743A.192;

(c) Treatments that do not conform to acceptable and customary standards of medical practice;

(d) Treatments for which there is insufficient data to determine efficacy; or

(e) Abortion if the insurer offering the health benefit plan excluded coverage for abortion in all of its individual, small employer and large employer group plans during the 2017 plan year.

(8) If services, drugs, devices, products or procedures required by this section are provided by an out-of-network provider, the health benefit plan must cover the services, drugs, devices, products or procedures without imposing any cost-sharing requirement on the enrollee if:

(a) There is no in-network provider to furnish the service, drug, device, product or procedure

that is geographically accessible or accessible in a reasonable amount of time, as defined by the Department of Consumer and Business Services by rule consistent with the requirements for provider networks in ORS 743B.505; or

(b) An in-network provider is unable or unwilling to provide the service in a timely manner.

(9) An insurer may offer to a religious employer a health benefit plan that does not include coverage for contraceptives or abortion procedures that are contrary to the religious employer's religious tenets only if the insurer notifies in writing all employees who may be enrolled in the health benefit plan of the contraceptives and procedures the employer refuses to cover for religious reasons.

(10) If the Department of Consumer and Business Services concludes that enforcement of this section may adversely affect the allocation of federal funds to this state, the department may grant an exemption to the requirements but only to the minimum extent necessary to ensure the continued receipt of federal funds.

(11) An insurer that is subject to this section shall make readily accessible to enrollees and potential enrollees, in a consumer-friendly format, information about the coverage of contraceptives by each health benefit plan and the coverage of other services, drugs, devices, products and procedures described in this section. The insurer must provide the information:

(a) On the insurer's website; and

(b) In writing upon request by an enrollee or potential enrollee.

(12) This section does not prohibit an insurer from using reasonable medical management techniques to determine the frequency, method, treatment or setting for the coverage of services, drugs, devices, products and procedures described in subsection (2) of this section, other than coverage required by subsection (2)(g) and (j) of this section, if the techniques:

(a) Are consistent with the coverage requirements of subsection (2) of this section; and

(b) Do not result in the wholesale or indiscriminate denial of coverage for a service.

SECTION 8. ORS 743A.262 is amended to read:

743A.262. Notwithstanding any other provision of law, a health benefit plan that is not a grandfathered health plan:

(1) Must provide coverage of preventive health services [*as prescribed by the United States Department of Health and Human Services pursuant to*] **described in** 42 U.S.C. 300gg-13 [*in rules adopted and in effect on January 1, 2017*] **as adopted by rule by the Department of Consumer and Business Services**; and

(2) May not impose cost-sharing requirements on an enrollee for preventive health services, except as allowed by [*federal law*] **rules adopted by the department**.

SECTION 9. ORS 743B.005 is amended to read:

743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and 743B.128:

(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 743B.012 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 743B.010 to 743B.013; or

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

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

(7) "Eligible employee" means an employee who is eligible for coverage under a group health benefit plan.

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

(9) "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.

(10) "Exchange" means [*an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041*] **the health insurance exchange administered by the Department of Consumer and Business Services in accordance with ORS 741.002**.

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

(12) "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.

(13)(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.

(14) "Grandfathered health plan" has the meaning prescribed by rule by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) that is in effect on January 1, 2017.

(15) "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.

(16)(a) "Health benefit plan" means any:

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

(B) Subscriber contract of a health care service contractor as defined in ORS 750.005; 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 three 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.

(17) "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.

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

(19) "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.

(20) "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.

(21) "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.

(22) "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.

(23) "Rating period" means the 12-month calendar period for which premium rates established

by a carrier are in effect, as determined by the carrier.

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

(25) "Small employer" means an employer who employed an average of at least one but not more than 50 full-time equivalent employees on business days during the preceding calendar year and who employs at least one full-time equivalent employee on the first day of the plan year, determined in accordance with a methodology prescribed by the Department of Consumer and Business Services by rule.

SECTION 10. ORS 743B.013 is amended to read:

743B.013. (1) A health benefit plan issued to a small employer:

(a) Other than a grandfathered health plan, must cover essential health benefits [*consistent with 42 U.S.C. 300gg-11*].

(b) May require an affiliation period that does not exceed two months for an enrollee or 90 days for a late enrollee.

(c) May not apply a preexisting condition exclusion to any enrollee.

(2) Late enrollees in a small employer health benefit plan may be subjected to a group eligibility waiting period that does not exceed 90 days.

(3) Each small employer health benefit plan is renewable with respect to all eligible enrollees at the option of the policyholder, small employer or contract holder unless:

(a) The policyholder, small employer or contract holder fails to pay the required premiums.

(b) The policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) The number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) The small employer fails to comply with the contribution requirements under the health benefit plan.

(e) The carrier discontinues both offering and renewing all of the carrier's small employer health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

(A) Must give notice of the decision to the Department of Consumer and Business Services and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a specified service area, except that:

(i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if the cancellation is for a specified service area in the circumstances described in subparagraph (C) of this paragraph; and

(ii) The Director of the Department of Consumer and Business Services may specify a cancellation date other than the cancellation date specified in this subparagraph if the carrier is subject to a delinquency proceeding, as defined in ORS 734.014; and

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.

(f) The carrier discontinues both offering and renewing a small employer health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice to the department and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each small employer covered by the plan, all other small employer health benefit plans that the carrier offers to small employers in the specified service area. The carrier shall issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) The carrier discontinues both offering and renewing a health benefit plan, other than a grandfathered health plan, for all small employers in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

(h) The carrier discontinues both offering and renewing a grandfathered health plan for all small employers in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

(A) Offer in writing to each small employer covered by the plan, all other health benefit plans that the carrier offers to small employers in the specified service area.

(B) Issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013.

(C) Offer the plans at least 90 days prior to discontinuation.

(D) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(j) The Director of the Department of Consumer and Business Services orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

(k) In the case of a small employer health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

(L) In the case of a health benefit plan that is offered in the small employer market only to one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(4) A carrier may modify a small employer health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (3)(e), (g) and (h) of this section.

(5) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may not rescind the coverage of an enrollee in a small employer health benefit plan unless:

(a) The enrollee or a person seeking coverage on behalf of the enrollee:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(6) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may not rescind a small employer health benefit plan unless:

(a) The small employer or a representative of the small employer:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(7)(a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers. However, participation and contribution requirements shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the carrier. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing group health benefit plan, 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.

(b) A carrier may not deny a small employer's application for coverage under a health benefit plan based on participation or contribution requirements but may require small employers that do not meet participation or contribution requirements to enroll during the open enrollment period beginning November 15 and ending December 15.

(8) Premium rates for small employer health benefit plans, except grandfathered health plans, are subject to the following provisions:

(a) Each carrier must file with the department the initial geographic average rate and any changes in the geographic average rate with respect to each health benefit plan issued by the carrier to small employers.

(b)(A) The variations in premium rates charged during a rating period for health benefit plans issued to small employers must be based solely on the factors specified in subparagraph (B) of this paragraph. A carrier may elect which of the factors specified in subparagraph (B) of this paragraph apply to premium rates for health benefit plans for small employers. All other factors must be applied in the same actuarially sound way to all small employer health benefit plans.

(B) The variations in premium rates described in subparagraph (A) of this paragraph may be based only on one or more of the following factors as prescribed by the department by rule:

(i) The ages of enrolled employees and their dependents, except that the rate for adults may not vary by more than three to one;

(ii) The level at which enrolled employees and dependents of enrolled employees engage in tobacco use, except that the rate may not vary by more than 1.5 to one; and

(iii) Adjustments to reflect differences in family composition.

(C) A carrier shall apply the carrier's schedule of premium rate variations as approved by the

department and in accordance with this paragraph. Except as otherwise provided in this section, the premium rate established by a carrier for a small employer health benefit plan applies uniformly to all employees of the small employer enrolled in that plan.

(c) Except as provided in paragraph (b) of this subsection, the variation in premium rates between different health benefit plans offered by a carrier to small employers must be based solely on objective differences in plan design or coverage, age, tobacco use and family composition and must not include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

(d) A carrier may not increase the rates of a health benefit plan issued to a small employer more than once in a 12-month period. Annual rate increases are effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the geographic average rate measured from the first day of the prior rating period to the first day of the new period; and

(B) Any adjustment attributable to changes in age and differences in family composition.

(9) Premium rates for grandfathered health plans are subject to requirements prescribed by the department by rule.

(10) In connection with the offering for sale of any health benefit plan to a small employer, each carrier shall make a reasonable disclosure as part of the carrier's solicitation and sales materials of:

(a) The full array of health benefit plans that are offered to small employers by the carrier;

(b) The authority of the carrier to adjust rates and premiums, and the extent to which the carrier considers age, tobacco use, family composition and geographic factors in establishing and adjusting rates and premiums; and

(c) The benefits and premiums for all health insurance coverage for which the employer is qualified.

(11)(a) Each carrier shall maintain at the carrier's principal place of business a complete and detailed description of the carrier's rating practices and renewal underwriting practices relating to the carrier's small employer health benefit plans, including information and documentation that demonstrate that the carrier's rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) A carrier offering a small employer health benefit plan shall file with the department at least once every 12 months an actuarial certification that the carrier is in compliance with ORS 743B.010 to 743B.013 and that the rating methods of the carrier are actuarially sound. Each certification must be in a uniform form and manner and must contain such information as specified by the department. The carrier shall retain a copy of each certification at the carrier's principal place of business. A carrier is not required to file the actuarial certification under this paragraph if the department has approved the carrier's rate filing within the preceding 12-month period.

(c) A carrier shall make the information and documentation described in paragraph (a) of this subsection available to the department upon request. Except as provided in ORS 743.018 and except in cases of violations of ORS 743B.010 to 743B.013, the information is proprietary and trade secret information and is not subject to disclosure to persons outside the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(12) A carrier may not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to sell health benefit plans of the carrier to small employer

groups based on a small employer group's anticipated claims experience.

(13) For purposes of this section, the date a small employer health benefit plan is continued is the anniversary date of the first issuance of the health benefit plan.

(14) A carrier shall include a provision that offers coverage to all eligible employees of a small employer and to all dependents of the eligible employees to the extent the employer chooses to offer coverage to dependents.

(15) All small employer health benefit plans must contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided by [*federal law and*] rules adopted by the department.

(16) A small employer health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

SECTION 11. ORS 743B.105 is amended to read:

743B.105. The following requirements apply to all group health benefit plans other than small employer health benefit plans covering two or more certificate holders:

(1) A carrier offering a group health benefit plan may not decline to offer coverage to any eligible prospective enrollee and may not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

(2) A group health benefit plan may not apply a preexisting condition exclusion to any enrollee but may impose:

(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

(b) A group eligibility waiting period for late enrollees that does not exceed 90 days.

(3) Each group health benefit plan shall contain a special enrollment period during which eligible employees and dependents may enroll for coverage, as provided by [*federal law and*] rules adopted by the Department of Consumer and Business Services.

(4)(a) A carrier shall issue to a group any of the carrier's group health benefit plans offered by the carrier for which the group is eligible, if the group applies for the plan, agrees to make the required premium payments and agrees to satisfy the other requirements of the plan.

(b) The department may waive the requirements of this subsection if the department finds that issuing a plan to a group or groups would endanger the carrier's ability to fulfill the carrier's contractual obligations or result in financial impairment of the carrier.

(5) Each group health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder unless:

(a) The policyholder fails to pay the required premiums.

(b) The policyholder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) The number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) The policyholder fails to comply with the contribution requirements under the plan.

(e) The carrier discontinues both offering and renewing, all of the carrier's group health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

(A) Must give notice of the decision to the department and to all policyholders covered by the

plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a specified service area, except that:

(i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if the cancellation is for a specified service area in the circumstances described in subparagraph (C) of this paragraph; and

(ii) The Director of the Department of Consumer and Business Services may specify a cancellation date other than the cancellation date specified in this subparagraph if the carrier is subject to a delinquency proceeding, as defined in ORS 734.014; and

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.

(f) The carrier discontinues both offering and renewing a group health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice of the decision to the department and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other group health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) The carrier discontinues both offering and renewing a group health benefit plan, other than a grandfathered health plan, for all groups in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

(h) The carrier discontinues both offering and renewing a grandfathered health plan for all groups in this state or in a specified service are within this state, other than a plan discontinued under paragraph (f) of this subsection.

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans that the carrier offers to groups in the specified service area.

(B) Offer the plans at least 90 days prior to discontinuation.

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(j) The director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

(k) In the case of a group health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

(L) In the case of a health benefit plan that is offered in the group market only to one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(6) A carrier may modify a group health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (5)(e), (g) and (h) of this section.

(7) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind the coverage of an enrollee under a group health benefit plan unless:

(a) The enrollee:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(8) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind a group health benefit plan unless:

(a) The plan sponsor or a representative of the plan sponsor:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(9) A group health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

SECTION 12. ORS 414.025 is amended to read:

414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially applicable statutory definition requires otherwise:

(1)(a) "Alternative payment methodology" means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services.

(b) "Alternative payment methodology" includes, but is not limited to:

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

(2) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

(3) "Behavioral health clinician" means:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

(c) A licensed nurse practitioner with a specialty in psychiatric mental health;

(d) A licensed clinical social worker;

(e) A licensed professional counselor or licensed marriage and family therapist;

(f) A certified clinical social work associate;

(g) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

(h) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

(4) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

(5) "Behavioral health home" means a mental health disorder or substance use disorder treatment organization, as defined by the Oregon Health Authority by rule, that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders.

(6) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security Income payments.

(7) "Community health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services such as first aid or blood pressure screening.

(8) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.572.

(9) "Dually eligible for Medicare and Medicaid" means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

(a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or

(b) Enrolled in Part B of Title XVIII of the Social Security Act.

(10)(a) "Family support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides supportive services to and has experience parenting a child who:

(A) Is a current or former consumer of mental health or addiction treatment; or

(B) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "family support specialist" may be a peer wellness specialist or a peer support specialist.

(11) "Global budget" means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

(12) "Health insurance exchange" or "exchange" means [*an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041*] **the health insurance exchange administered by the Department of Consumer and Business Services in accordance with ORS 741.002**.

(13) "Health services" means at least so much of each of the following as are funded by the Legislative Assembly based upon the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690:

(a) Services required by federal law to be included in the state's medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner licensed under ORS 678.375, a behavioral health clinician or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state's medical assistance program;

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

(14) "Income" has the meaning given that term in ORS 411.704.

(15)(a) "Integrated health care" means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:

(A) Mental illness.

(B) Substance use disorders.

(C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.

(E) Developmental risks and conditions.

(F) Stress-related physical symptoms.

(G) Preventive care.

(H) Ineffective patterns of health care utilization.

(b) As used in this subsection, "other care team members" includes but is not limited to:

(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;

(B) Peer wellness specialists;

(C) Peer support specialists;

(D) Community health workers who have completed a state-certified training program;

(E) Personal health navigators; or

(F) Other qualified individuals approved by the Oregon Health Authority.

(16) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the department or the authority may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(17) "Medical assistance" means so much of the medical, mental health, preventive, supportive, palliative and remedial care and services as may be prescribed by the authority according to the standards established pursuant to ORS 414.065, including premium assistance and payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of health services and for services described in ORS 414.710.

(18) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. Except as provided in ORS 411.439 and 411.447, "medical assistance" does not include care or services for a resident of a nonmedical public institution.

(19) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS 414.655 and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

(20) "Peer support specialist" means any of the following individuals who meet qualification criteria adopted by the authority under ORS 414.665 and who provide supportive services to a current or former consumer of mental health or addiction treatment:

(a) An individual who is a current or former consumer of mental health treatment; or

(b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from an addiction disorder.

(21) "Peer wellness specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

(22) "Person centered care" means care that:

(a) Reflects the individual patient's strengths and preferences;

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

(c) Is based upon the patient's goals and will assist the patient in achieving the goals.

(23) "Personal health navigator" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

(24) "Prepaid managed care health services organization" means a managed dental care, mental health or chemical dependency organization that contracts with the authority under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.

(25) "Quality measure" means the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 414.638.

(26) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

(27)(a) "Youth support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

(A) Is not older than 30 years of age; and

(B)(i) Is a current or former consumer of mental health or addiction treatment; or

(ii) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "youth support specialist" may be a peer wellness specialist or a peer support specialist.
