

House Bill 2922

Sponsored by Representatives DEMBROW, WILLIAMSON, Senator SHIELDS; Representatives BAILEY, BARKER, BARNHART, BUCKLEY, FREDERICK, GALLEGOS, GARRETT, GOMBERG, GORSEK, GREENLICK, HARKER, HOLVEY, HOYLE, KENY-GUYER, NATHANSON, REARDON, TOMEI, VEGA PEDERSON, WITT, Senators DINGFELDER, MONROE

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**.

Establishes Affordable Health Care for All Oregon Plan, operated by Oregon Health Authority according to policies established by Affordable Health Care for All Oregon Board. Provides comprehensive health care coverage to all individuals residing or working in Oregon. Supplants coverage by private insurers for health services covered by plan. Requires public employees to be covered by plan. Creates Affordable Health Care for All Oregon Fund. Continuously appropriates moneys in fund to authority. Provides for implementation of plan on January 1, 2017.

Makes provisions establishing board operative on January 1, 2016. Requires board to establish policies and approve administrative rules for certificate of need process. Expands certificate of need to include both new and existing health care facilities and coordinated care organizations.

Repeals Oregon Health Insurance Exchange, Oregon Medical Insurance Pool Board, Oregon Medical Insurance Pool, Office of Private Health Partnerships, Family Health Insurance Assistance Program and private health option under Health Care for All Oregon Children program on January 1, 2017.

Appropriates moneys from General Fund to authority for purposes of plan.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to statewide coverage of health care; creating new provisions; amending ORS 65.957, 192.556, 243.105, 243.125, 243.135, 243.160, 243.215, 243.275, 243.860, 243.864, 243.866, 243.868, 243.886, 291.055, 411.402, 413.011, 413.017, 413.032, 413.037, 413.201, 414.041, 414.231, 430.315, 433.443, 442.015, 442.315, 442.325, 705.145, 731.036, 734.790, 743.402, 743.730, 743.748, 743.766, 743.767, 743.769, 743A.001, 743A.012, 743A.070, 743A.080, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110, 743A.120, 743A.124, 743A.141, 743A.144, 743A.148, 743A.160, 743A.168, 743A.170, 743A.175, 743A.184, 743A.188, 743A.190, 743A.192, 744.704, 746.600, 748.603 and 750.055 and section 1, chapter 867, Oregon Laws 2009, and section 1, chapter 101, Oregon Laws 2012; repealing ORS 414.825, 414.826, 414.828, 414.831, 414.839, 414.841, 414.842, 414.844, 414.846, 414.848, 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866, 414.868, 414.870, 414.872, 735.600, 735.605, 735.610, 735.612, 735.614, 735.615, 735.616, 735.620, 735.625, 735.630, 735.635, 735.640, 735.645, 735.650, 735.700, 735.701, 735.702, 735.703, 735.705, 735.707, 735.709, 735.710, 735.712, 741.001, 741.002, 741.025, 741.027, 741.029, 741.031, 741.101, 741.105, 741.201, 741.220, 741.222, 741.250, 741.255, 741.300, 741.310, 741.340, 741.381, 741.390, 741.500, 741.510, 741.520, 741.540, 741.900, 743.822, 743.826 and 746.222 and sections 1, 2, 3, 4 and 5, chapter 47, Oregon Laws 2010; appropriating money; and declaring an emergency.

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

ESTABLISHMENT OF THE AFFORDABLE HEALTH CARE FOR ALL OREGON PLAN

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

1 **SECTION 1.** (1) The Affordable Health Care for All Oregon **Plan is established** to ensure
2 access to quality, patient-centered and affordable health care for all individuals living or
3 working in Oregon, to improve the public's health and to control the cost of health care for
4 the benefit of individuals, families, businesses and society.

5 (2) The **plan shall pay the costs of medically necessary health services** in the following
6 categories within the scope prescribed by the Affordable Health Care for All Oregon Board,
7 excluding health services provided only for cosmetic purposes:

- 8 (a) Primary and preventive care, including health education;
- 9 (b) Specialty care;
- 10 (c) Inpatient and outpatient hospital care;
- 11 (d) Emergency care;
- 12 (e) Home health care;
- 13 (f) Prescription drugs according to a drug formulary;
- 14 (g) Durable medical equipment;
- 15 (h) Mental health services;
- 16 (i) Substance abuse treatment;
- 17 (j) Dental services;
- 18 (k) Chiropractic and naturopathic services;
- 19 (L) Certified nurse midwife services;
- 20 (m) Basic vision and vision correction;
- 21 (n) Diagnostic imaging, laboratory services and other diagnostic and evaluation services;
- 22 (o) Inpatient and outpatient rehabilitative services;
- 23 (p) Emergency transportation;
- 24 (q) Translation of spoken and written language;
- 25 (r) Hospice care;
- 26 (s) Podiatry;
- 27 (t) Acupuncture; and
- 28 (u) Dialysis.

29 (3) A person and the immediate family members of a person are **eligible to enroll** in the
30 plan if the person:

- 31 (a) Resides in this state; or
- 32 (b) Is employed in this state.

33 (4) Copayments, deductibles or other forms of **cost sharing may not be imposed** on
34 enrollees under the plan.

35 (5) Enrollees in the plan may **choose any health care provider** licensed or certified in this
36 state or in another state for services within the scope of the provider's license or certifi-
37 cation.

38 (6) Within the scope of services covered within each category, **enrollees and their health**
39 **care providers shall determine what treatment** is medically necessary.

40 (7) A health care provider may not discriminate against any enrollee on the basis of race,
41 religion, nationality, sex, sexual orientation, age, wealth or any basis prohibited by the civil
42 rights laws of this state.

43 (8) A health care provider must accept payment from the plan as payment in full and
44 may not bill a patient for an amount exceeding the payment made by the plan.

45 (9) A payment under the plan to a health care facility for operational expenses may not

1 be used by the facility to pay for or to replace other funds used to pay for capital expen-
2 ditures.

3 (10) Administrative costs of the plan may not exceed:

4 (a) Twelve percent of total costs of the plan during the first two years of plan operation.

5 (b) Eight percent of total costs of the plan during the third and fourth years of plan op-
6 eration.

7 (c) Five percent of total costs of the plan during the fifth and subsequent years of plan
8 operation.

9 (11) Loss of eligibility due to no longer meeting the criteria in subsection (3) of this sec-
10 tion shall be considered a qualifying event. The Oregon Health Authority shall be considered
11 to be a plan sponsor of a group health plan for purposes of continuation coverage required
12 by 29 U.S.C. 1161 and shall notify the enrollee losing coverage and the immediate family
13 members of the enrollee losing coverage of the option to continue coverage at the enrollee's
14 own expense.

15 **SECTION 2.** No later than January 1, 2019, the Affordable Health Care for All Oregon
16 Board established under section 5 of this 2013 Act shall develop and submit to the Legislative
17 Assembly a recommendation for the coverage of long term care services by the Affordable
18 Health Care for All Oregon Plan.

19 **SECTION 3.** Notwithstanding any other provision of law, an insurer with a certificate of
20 authority to transact insurance issued by the Department of Consumer and Business Ser-
21 vices may not offer in this state a policy or certificate of health insurance that covers the
22 health services provided under the Affordable Health Care for All Oregon Plan.

23 **SECTION 4.** Actions taken by insurers may not be considered to be the transaction of
24 insurance for purposes of the Insurance Code if the actions are:

25 (1) Taken in accordance with the requirements adopted pursuant to sections 1, 7 and 10
26 of this 2013 Act; and

27 (2) Approved by the Oregon Health Authority or the Affordable Health Care for All
28 Oregon Board.

29
30 **AFFORDABLE HEALTH CARE FOR ALL OREGON BOARD**

31
32 **SECTION 5.** (1) There is established the Affordable Health Care for All Oregon Board,
33 consisting of nine members who represent each congressional district in the state. The
34 Governor shall appoint the members of the board subject to confirmation by the Senate in
35 the manner prescribed by ORS 171.562 and 171.565. The membership must include:

36 (a) A licensed or certified health care provider;

37 (b) A public health official;

38 (c) A representative of organized labor; and

39 (d) A representative of business who is not employed by a health care provider, phar-
40 maceutical company, health insurer or medical supply company.

41 (2) The term of office of each member is four years and begins on the January 2 following
42 appointment. A new term begins on the expiration of the previous term. A member is eligible
43 for reappointment. The Governor shall appoint a person to fill any vacancy, subject to con-
44 firmation by the Senate. Any appointment to a vacant position shall become immediately
45 effective for the unexpired term.

1 (3) The board shall select one of its members as chairperson and another as vice chair-
2 person, for such terms and with duties and powers necessary for the performance of the
3 functions of such offices as the board determines.

4 (4) A majority of the members of the board constitutes a quorum for the transaction of
5 business.

6 (5) The board shall meet at least once every three months at a place, day and hour de-
7 termined by the chairperson. The board may also meet at other times and places specified
8 by the call of the chairperson or of a majority of the members of the board.

9 (6) Consistent with ORS chapter 244, the board shall adopt rules of ethics and definitions
10 of conflicts of interest for determining the circumstances under which members of the board
11 must recuse themselves from voting.

12 (7) The Oregon Health Authority shall provide staff support for the board.

13 (8) A member of the board is entitled to compensation and expenses as provided in ORS
14 292.495 for participation in board and any subcommittee meetings.

15 (9) In accordance with applicable provisions of ORS chapter 183, the board may adopt
16 rules necessary for the administration of the laws that the board is charged with adminis-
17 tering.

18 **SECTION 6.** Notwithstanding section 5 of this 2013 Act, of the members first appointed
19 to the Affordable Health Care for All Oregon Board:

20 (1) Three shall serve for terms ending December 31, 2017.

21 (2) Three shall serve for terms ending December 31, 2018.

22 (3) Three shall serve for terms ending December 31, 2019.

23 **SECTION 7.** The Affordable Health Care for All Oregon Board is responsible for the de-
24 velopment, implementation, management and oversight of the Affordable Health Care for
25 All Oregon Plan established in section 1 of this 2013 Act, including but not limited to all of
26 the following duties:

27 (1) Determining and regularly updating the scope of coverage within each category de-
28 scribed in section 1 (2) of this 2013 Act in consultation with enrollees and guided by
29 evidence-based practices that integrate clinical expertise, patient values and current re-
30 search.

31 (2) Approving the package of benefits covered in the plan.

32 (3) Overseeing management of the Affordable Health Care for All Oregon Fund.

33 (4) Determining policies and adopting rules to guide the operation of the plan, including
34 but not limited to:

35 (a) Establishing eligibility standards for enrollment, including standards for presumptive
36 eligibility determinations;

37 (b) Ensuring meaningful access by enrollees to quality health services included in the
38 benefit package;

39 (c) Ensuring that the plan covers health services that:

40 (A) Are evidence-based and cost-effective in promoting health; and

41 (B) Emphasize disease prevention and health promotion;

42 (d) Developing quality of care indicators;

43 (e) Establishing policies regarding conflicts of interest for health care providers and
44 health care facilities;

45 (f) Regularly soliciting input from the public, including individuals with specialized health

1 service needs, through district advisory committees appointed under section 9 of this 2013
2 Act, and other means;

3 (g) Hiring an executive director for the plan who serves at the pleasure of the board;

4 (h) Approving contracts for services provided by health care facilities;

5 (i) Approving contracts with pharmaceutical and durable medical equipment providers;

6 (j) Seeking all waivers, exemptions and agreements from federal, state and local govern-
7 ment sources that are necessary to provide funding for the plan; and

8 (k) Ensuring that implementation of the plan affects all individuals equitably, regardless
9 of health status, age, disability, employment status or income.

10 (5) Partnering with public health agencies to improve the public's health.

11 (6) Reporting, at least annually, to the Legislative Assembly on the performance of the
12 plan and recommending needed legislative changes.

13 (7) Establishing an appeal process, in accordance with ORS chapter 183, and an ombuds-
14 man office for both health care providers and enrollees to appeal adverse determinations by
15 the board or the Oregon Health Authority and to resolve complaints.

16 (8) Submitting to the Legislative Assembly an estimate of the funding needed to operate
17 the plan.

18 (9) Ensuring an annual audit is conducted of the revenue and expenses of the plan.

19 (10) Establishing procedures and terms for payments to in-state and out-of-state health
20 care providers for covered services provided under the plan.

21 (11) Establishing policies for the certificate of need process under ORS 442.315.

22 (12) Seeking federal certification of the plan as a Medicare Advantage plan.

23 **SECTION 8.** (1) The Affordable Health Care for All Oregon Board shall establish a pro-
24 gram to operate during the first four years of operation of the Affordable Health Care for
25 All Oregon Plan to pay for or to reimburse the costs of retraining for workers who are dis-
26 placed by the implementation of the plan. The Oregon Health Authority shall administer the
27 program.

28 (2) The board shall apply for federal and private gifts and grants available to operate the
29 program.

30 (3) A worker is eligible for no more than 24 months of retraining under this section.

31 **SECTION 9.** (1) The Affordable Health Care for All Oregon Board shall appoint for each
32 congressional district in this state a district advisory committee consisting of residents of
33 the district. Each advisory committee shall solicit input, receive complaints, conduct public
34 hearings, facilitate accountability or assist the board in any manner deemed appropriate by
35 the board to meet the health service needs of residents of the congressional district.

36 (2) The Oregon Health Authority shall provide staff support to each district advisory
37 committee.

38
39 **DUTIES OF THE OREGON HEALTH AUTHORITY IN ADMINISTER-**
40 **ING THE AFFORDABLE HEALTH CARE FOR ALL OREGON PLAN**

41
42 **SECTION 10.** The Oregon Health Authority, under the direction, policies and oversight
43 of the Affordable Health Care for All Oregon Board, shall:

44 (1) Adopt rules approved by the board necessary for carrying out the authority's duties
45 under this section;

1 admission.

2 (b) "Ambulatory surgical center" does not mean:

3 (A) Individual or group practice offices of private physicians or dentists that do not contain a
 4 distinct area used for outpatient surgical treatment on a regular and organized basis, or that only
 5 provide surgery routinely provided in a physician's or dentist's office using local anesthesia or
 6 conscious sedation; or

7 (B) A portion of a licensed hospital designated for outpatient surgical treatment.

8 [(4) "Budget" means the projections by the hospital for a specified future time period of expen-
 9 ditures and revenues with supporting statistical indicators.]

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

11 (5) "Develop" means to undertake those activities that on their completion will result in the
 12 offer of a new institutional health service or the incurring of a financial obligation, as defined under
 13 applicable state law, in relation to the offering of such a health service.

14 (6) "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an
 15 expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a
 16 donation or grant in lieu of an expenditure but not including any interest thereon.

17 (7) "Freestanding birthing center" means a facility licensed for the primary purpose of per-
 18 forming low risk deliveries.

19 (8) "Governmental unit" means the state, or any county, municipality or other political subdi-
 20 vision, or any related department, division, board or other agency.

21 (9) "Gross revenue" means the sum of daily hospital service charges, ambulatory service
 22 charges, ancillary service charges and other operating revenue. "Gross revenue" does not include
 23 contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

24 (10)(a) "Health care facility" means:

25 (A) A hospital;

26 (B) A long term care facility;

27 (C) An ambulatory surgical center;

28 (D) A freestanding birthing center; or

29 (E) An outpatient renal dialysis center.

30 (b) "Health care facility" does not mean:

31 (A) A residential facility licensed by the Department of Human Services or the Oregon Health
 32 Authority under ORS 443.415;

33 (B) An establishment furnishing primarily domiciliary care as described in ORS 443.205;

34 (C) A residential facility licensed or approved under the rules of the Department of Corrections;

35 (D) Facilities established by ORS 430.335 for treatment of substance abuse disorders; or

36 (E) Community mental health programs or community developmental disabilities programs es-
 37 tablished under ORS 430.620.

38 (11) "Health maintenance organization" or "HMO" means a public organization or a private
 39 organization organized under the laws of any state that:

40 (a) Is a qualified HMO under section 1310 (d) of the U.S. Public Health Services Act; or

41 (b)(A) Provides or otherwise makes available to enrolled participants health care services, in-
 42 cluding at least the following basic health care services:

43 (i) Usual physician services;

44 (ii) Hospitalization;

45 (iii) Laboratory;

- 1 (iv) X-ray;
- 2 (v) Emergency and preventive services; and
- 3 (vi) Out-of-area coverage;

4 (B) Is compensated, except for copayments, for the provision of the basic health care services
 5 listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic
 6 rate basis; and

7 (C) Provides physicians' services primarily directly through physicians who are either employees
 8 or partners of such organization, or through arrangements with individual physicians or one or more
 9 groups of physicians organized on a group practice or individual practice basis.

10 (12) "Health services" means clinically related diagnostic, treatment or rehabilitative services,
 11 and includes alcohol, drug or controlled substance abuse and mental health services that may be
 12 provided either directly or indirectly on an inpatient or ambulatory patient basis.

13 (13) "Hospital" means:

14 (a) A facility with an organized medical staff and a permanent building that is capable of pro-
 15 viding 24-hour inpatient care to two or more individuals who have an illness or injury and that
 16 provides at least the following health services:

- 17 (A) Medical;
- 18 (B) Nursing;
- 19 (C) Laboratory;
- 20 (D) Pharmacy; and
- 21 (E) Dietary; or

22 (b) A special inpatient care facility as that term is defined by the Oregon Health Authority by
 23 rule.

24 (14) "Institutional health services" means health services provided in or through health care
 25 facilities and includes the entities in or through which such services are provided.

26 (15) "Intermediate care facility" means a facility that provides, on a regular basis, health-related
 27 care and services to individuals who do not require the degree of care and treatment that a hospital
 28 or skilled nursing facility is designed to provide, but who because of their mental or physical con-
 29 dition require care and services above the level of room and board that can be made available to
 30 them only through institutional facilities.

31 (16) "Long term care facility" means a facility with permanent facilities that include inpatient
 32 beds, providing medical services, including nursing services but excluding surgical procedures ex-
 33 cept as may be permitted by the rules of the Director of Human Services, to provide treatment for
 34 two or more unrelated patients. "Long term care facility" includes skilled nursing facilities and
 35 intermediate care facilities but may not be construed to include facilities licensed and operated
 36 pursuant to ORS 443.400 to 443.455.

37 *[(17) "New hospital" means a facility that did not offer hospital services on a regular basis within*
 38 *its service area within the prior 12-month period and is initiating or proposing to initiate such services.*
 39 *"New hospital" also includes any replacement of an existing hospital that involves a substantial in-*
 40 *crease or change in the services offered.]*

41 *[(18) "New skilled nursing or intermediate care service or facility" means a service or facility that*
 42 *did not offer long term care services on a regular basis by or through the facility within the prior*
 43 *12-month period and is initiating or proposing to initiate such services. "New skilled nursing or inter-*
 44 *mediate care service or facility" also includes the rebuilding of a long term care facility, the relocation*
 45 *of buildings that are a part of a long term care facility, the relocation of long term care beds from one*

1 facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed ca-
2 pacity, whichever is the lesser, within a two-year period.]

3 [(19)] (17) "Offer" means that the health care facility holds itself out as capable of providing,
4 or as having the means for the provision of, specified health services.

5 [(20)] (18) "Outpatient renal dialysis facility" means a facility that provides renal dialysis ser-
6 vices directly to outpatients.

7 [(21)] (19) "Person" means an individual, a trust or estate, a partnership, a corporation (includ-
8 ing associations, joint stock companies and insurance companies), a state, or a political subdivision
9 or instrumentality, including a municipal corporation, of a state.

10 [(22)] (20) "Skilled nursing facility" means a facility or a distinct part of a facility, that is pri-
11 marily engaged in providing to inpatients skilled nursing care and related services for patients who
12 require medical or nursing care, or an institution that provides rehabilitation services for the re-
13 habilitation of individuals who are injured or sick or who have disabilities.

14 **SECTION 12.** ORS 442.315 is amended to read:

15 442.315. (1) Any [*new hospital or new skilled nursing or intermediate care service or*] **health care**
16 facility not excluded pursuant to ORS 441.065 [*shall*] **must** obtain a certificate of need from the
17 Oregon Health Authority prior to an offering or development.

18 (2) The authority shall adopt rules, **in compliance with policies developed and subject to**
19 **approval by the Affordable Health Care for All Oregon Board**, specifying criteria and procedures
20 for [*making decisions as to the need for the new*] **approving certificates of need for** services or fa-
21 cilities.

22 (3)(a) An applicant for a certificate of need shall apply to the authority on forms provided for
23 this purpose by **the authority by** rule.

24 (b) An applicant shall pay a fee prescribed as provided in this section. Subject to the approval
25 of the [*Oregon Department of Administrative Services*] **board**, the authority shall prescribe applica-
26 tion fees, based on the complexity and scope of the proposed project.

27 (4) The authority shall [*be the decision-making authority for the purpose of certificates*] **issue a**
28 **proposed order with respect to an application for a certificate** of need.

29 (5)(a) An applicant or any affected person who is dissatisfied with the proposed [*decision*] **order**
30 of the authority is entitled to an informal hearing [*in the course of review and*] before a final [*deci-*
31 *sion is rendered*] **order is issued.**

32 (b) [*Following a final decision being rendered by the authority,*] **The authority shall prescribe**
33 **by rule a time frame within which** an applicant or any affected person may request a reconsid-
34 eration [*hearing pursuant to ORS chapter 183*] **of or a rehearing on a final order.**

35 (c) [*In any proceeding brought by an affected person or an applicant challenging an authority de-*
36 *cision under this subsection, the authority shall follow procedures*] **All proceedings under this sub-**
37 **section shall be conducted** consistent with the provisions of ORS chapter 183 relating to [*a*]
38 contested case **procedures.**

39 (6) Once a certificate of need has been issued, it may not be revoked or rescinded unless it was
40 acquired by fraud or deceit. However, if the authority finds that a person is offering or developing
41 a project that is not within the scope of the certificate of need, the authority may limit the project
42 as specified in the issued certificate of need or reconsider the application. A certificate of need is
43 not transferable.

44 (7) Nothing in this section applies to any [*hospital, skilled nursing or intermediate care service*
45 *or*] **health care** facility that seeks to replace equipment with equipment of similar basic technolog-

1 ical function or an upgrade that improves the quality or cost-effectiveness of the service provided.
 2 Any person acquiring such replacement or upgrade shall file a letter of intent for the project in
 3 accordance with the rules of the authority if the price of the replacement equipment or upgrade
 4 exceeds \$1 million.

5 (8) *[Except as required in subsection (1) of this section for a new hospital or new skilled nursing*
 6 *or intermediate care service or facility not operating as a Medicare swing bed program, nothing in]*
 7 This section *[requires]* **does not require** a rural hospital as defined in ORS 442.470 (5)(a)(A) and (B)
 8 to obtain a certificate of need.

9 (9) *[Nothing in this section applies to basic health services, but basic health services do not*
 10 *include]* **This section applies to:**

- 11 (a) Magnetic resonance imaging scanners;
- 12 (b) Positron emission tomography scanners;
- 13 (c) Cardiac catheterization equipment;
- 14 (d) Megavoltage radiation therapy equipment;
- 15 (e) Extracorporeal shock wave lithotriptors;
- 16 (f) Neonatal intensive care;
- 17 (g) Burn care;
- 18 (h) Trauma care;
- 19 (i) Inpatient psychiatric services;
- 20 (j) Inpatient chemical dependency services;
- 21 (k) Inpatient rehabilitation services;
- 22 (L) Open heart surgery; or
- 23 (m) Organ transplant services.

24 **(10) This section does not apply to health services offered in or through a hospital li-**
 25 **censed under ORS chapter 441 except for:**

- 26 (a) **Skilled or intermediate care nursing services offered in a hospital; and**
- 27 (b) **The services specified in section (9) of this section.**

28 *[(10)]* (11) In addition to any other remedy provided by law, whenever it appears that any person
 29 is engaged in, or is about to engage in, any acts that constitute a violation of this section, or any
 30 rule **adopted** or order issued by the authority under this section, the authority may institute pro-
 31 ceedings in the circuit courts to enforce obedience to *[such]* **the** statute, rule or order by injunction
 32 or by other processes, mandatory or otherwise.

33 *[(11) As used in this section, "basic health services" means health services offered in or through*
 34 *a hospital licensed under ORS chapter 441, except skilled nursing or intermediate care nursing facili-*
 35 *ties or services and those services specified in subsection (9) of this section.]*

36 **SECTION 13.** ORS 442.325 is amended to read:

37 442.325. (1) A certificate of need shall be required for the development or establishment of a
 38 health care facility of any *[new]* health maintenance organization **or coordinated care**
 39 **organization.**

40 (2) Any activity of a health maintenance organization **or coordinated care organization that**
 41 *[which]* does not involve the direct delivery of health services, as distinguished from arrangements
 42 for indirect delivery of health services through contracts with providers, shall be exempt from cer-
 43 tificate of need review.

44 (3) *[Nothing in ORS 244.050, 431.250,]* **ORS** 441.015 to 441.087[,] **and** 442.015 to 442.420 *[and*
 45 *442.450 applies]* **do not apply** to any decision of a health maintenance organization **or coordinated**

1 **care organization** involving its organizational structure, its arrangements for financing health ser-
 2 vices, the terms of its contracts with enrolled beneficiaries or its scope of benefits.

3 (4) With the exception of certificate of need requirements, when applicable[,]:

4 (a) The licensing and regulation of health maintenance organizations shall be controlled by ORS
 5 750.005 to 750.095 and statutes incorporated by reference therein.

6 (b) **The certification of coordinated care organizations shall be controlled by ORS 414.625.**

7 (5) It is the policy of ORS [244.050, 431.250,] **414.620, 414.625**, 441.015 to 441.087[,] **and** 442.015
 8 to 442.420 [*and 442.450*] to encourage the growth of health maintenance organizations [*as an*] **and**
 9 **coordinated care organizations** as alternative delivery [*system*] **systems** and to provide the facil-
 10 ities for the provision of quality health care to the present and future members who may enroll
 11 within their defined service area.

12 (6)(a) It is also the policy of ORS [244.050, 431.250,] **414.620, 414.625**, 441.015 to 441.087[,] **and**
 13 442.015 to 442.420 [*and 442.450*] to consider the special needs and circumstances of health mainte-
 14 nance organizations **and coordinated care organizations**. Such needs and circumstances include
 15 the needs of and costs to members and projected members of [*the health maintenance*] **each** organ-
 16 ization in obtaining health services and the potential for a reduction in the use of inpatient care in
 17 the community through an extension of preventive health services and the provision of more sys-
 18 tematic and comprehensive health services. The consideration of a new health service proposed by
 19 a health maintenance organization **or a coordinated care organization** shall also address the
 20 availability and cost of obtaining the proposed new health service from the existing providers in the
 21 area that are not **part of the** health maintenance [*organizations*] **organization or coordinated care**
 22 **organization**.

23 (b) The Oregon Health Authority shall issue a certificate of need for beds, services or equipment
 24 to meet the needs or reasonably anticipated needs of members of health maintenance organizations
 25 **and coordinated care organizations** when beds, services or equipment are not available from
 26 [*nonplan*] providers **outside of the organization**.

27
 28 **PUBLIC EMPLOYEE PARTICIPATION IN**
 29 **THE AFFORDABLE HEALTH CARE FOR ALL OREGON PLAN**

30
 31 **(Public Employees' Benefit Board)**

32
 33 **SECTION 14.** ORS 243.105 is amended to read:

34 243.105. As used in ORS 243.105 to 243.285, unless the context requires otherwise:

35 (1) "Benefit plan" includes, but is not limited to:

36 (a) Contracts for insurance or other benefits, including **supplemental** medical, dental[,] **or** vi-
 37 sion, life[,] **or** disability [*and other health care recognized by state law, and related services and sup-*
 38 *plies*]; **and**

39 [*(b) Comparable benefits for employees who rely on spiritual means of healing; and*]

40 [*(c) Self-insurance programs managed by the Public Employees' Benefit Board.*]

41 **(b) The Affordable Health Care for All Oregon Plan or comparable benefits for employees**
 42 **who rely on spiritual means of healing.**

43 (2) "Board" means the Public Employees' Benefit Board.

44 (3) "Carrier" means an insurance company or health care service contractor holding a valid
 45 certificate of authority from the Director of the Department of Consumer and Business Services, or

1 two or more companies or contractors acting together pursuant to a joint venture, partnership or
 2 other joint means of operation, or a board-approved guarantor of benefit plan coverage and com-
 3 pensation.

4 (4)(a) “Eligible employee” means an officer or employee of a state agency who elects to partic-
 5 ipate in one of the group benefit plans described in ORS 243.135. The term includes state officers
 6 and employees in the exempt, unclassified and classified service, and state officers and employees,
 7 whether or not retired, who:

8 (A) Are receiving a service retirement allowance, a disability retirement allowance or a pension
 9 under the Public Employees Retirement System or are receiving a service retirement allowance, a
 10 disability retirement allowance or a pension under any other retirement or disability benefit plan
 11 or system offered by the State of Oregon for its officers and employees;

12 (B) Are eligible to receive a service retirement allowance under the Public Employees Retire-
 13 ment System and have reached earliest retirement age under ORS chapter 238;

14 (C) Are eligible to receive a pension under ORS 238A.100 to 238A.245, and have reached earliest
 15 retirement age as described in ORS 238A.165; or

16 (D) Are eligible to receive a service retirement allowance or pension under another retirement
 17 benefit plan or system offered by the State of Oregon and have attained earliest retirement age
 18 under the plan or system.

19 (b) “Eligible employee” does not include individuals:

20 (A) Engaged as independent contractors;

21 (B) Whose periods of employment in emergency work are on an intermittent or irregular basis;

22 (C) Who are employed on less than half-time basis unless the individuals are employed in posi-
 23 tions classified as job-sharing positions, unless the individuals are defined as eligible under rules of
 24 the board;

25 (D) Appointed under ORS 240.309;

26 (E) Provided sheltered employment or make-work by the state in an employment or industries
 27 program maintained for the benefit of such individuals; or

28 (F) Provided student health care services in conjunction with their enrollment as students at a
 29 public university listed in ORS 352.002.

30 (5) “Family member” means an eligible employee’s spouse and any unmarried child or stepchild
 31 within age limits and other conditions imposed by the board with regard to unmarried children or
 32 stepchildren.

33 (6) “Payroll disbursing officer” means the officer or official authorized to disburse moneys in
 34 payment of salaries and wages of employees of a state agency.

35 (7) “Premium” means the monthly or other periodic charge for a benefit plan.

36 (8) “State agency” means every state officer, board, commission, department or other activity
 37 of state government.

38 **SECTION 15.** ORS 243.125 is amended to read:

39 243.125. (1) The Public Employees’ Benefit Board shall prescribe rules for the conduct of its
 40 business and for carrying out ORS 243.256. The board shall study all matters connected with the
 41 providing of adequate benefit plan coverage for eligible state employees on the best basis possible
 42 with relation both to the welfare of the employees and to the state. The board shall design benefits,
 43 devise specifications, analyze carrier responses to advertisements for bids and decide on the award
 44 of contracts. Contracts shall be signed by the chairperson on behalf of the board.

45 (2) In carrying out its duties under subsection (1) of this section, the goal of the board shall be

1 to provide a high quality plan of health and other benefits for state employees at a cost affordable
2 to both the employer and the employees.

3 (3) Subject to ORS chapter 183, the board may make rules not inconsistent with ORS 243.105 to
4 243.285 and 292.051 to determine the terms and conditions of eligible employee participation and
5 coverage.

6 (4) The board shall prepare specifications, invite bids and do acts necessary to award contracts
7 for *[health benefit plan and dental]* benefit plan coverage of eligible employees in accordance with
8 the criteria set forth in ORS 243.135 *[(1)] (2)*.

9 (5) The board may retain consultants, brokers or other advisory personnel when necessary and,
10 subject to the State Personnel Relations Law, shall employ such personnel as are required to per-
11 form the functions of the board.

12 **SECTION 16.** ORS 243.135 is amended to read:

13 243.135. (1) **Any person who is eligible to participate in a health benefit plan available to**
14 **state employees pursuant to ORS 243.105 to 243.285 shall enroll in the Affordable Health Care**
15 **for All Oregon Plan.**

16 (1) (2) *[Notwithstanding any other benefit plan contracted for and offered by the Public Employees'*
17 *Benefit Board]* **If the Public Employees' Benefit Board contracts for health benefit plans to**
18 **supplement coverage provided in the Affordable Health Care for All Oregon Plan,** the board
19 shall contract for a **supplemental** health benefit plan or plans best designed to meet the needs and
20 provide for the welfare of eligible employees and the state. In considering whether to enter into a
21 contract for a **supplemental health benefit** plan, the board shall place emphasis on:

- 22 (a) Employee choice among high quality plans;
- 23 (b) A competitive marketplace;
- 24 (c) Plan performance and information;
- 25 (d) Employer flexibility in plan design and contracting;
- 26 (e) Quality customer service;
- 27 (f) Creativity and innovation;
- 28 (g) Plan benefits as part of total employee compensation; and
- 29 (h) The improvement of employee health.

30 *[(2)] (3)* The board may approve more than one carrier for each type of **supplemental health**
31 **benefit** plan contracted for and offered but the number of carriers shall be held to a number con-
32 sistent with adequate service to eligible employees and their family members.

33 *[(3)] (4)* Where appropriate for a contracted and offered **supplemental** health benefit plan, the
34 board shall provide options under which an eligible employee may arrange coverage for family
35 members.

36 *[(4)] (5)* Payroll deductions for such costs as are not payable by the state may be made upon
37 receipt of a signed authorization from the employee indicating an election to participate in the
38 **supplemental health benefit** plan or plans selected and the deduction of a certain sum from the
39 employee's pay.

40 *[(5)] (6)* In developing any **supplemental** health benefit plan, the board may provide an option
41 of additional coverage for eligible employees and their family members at an additional cost or
42 premium.

43 *[(6)] (7)* Transfer of enrollment from one **supplemental health benefit** plan to another shall be
44 open to all eligible employees and their family members under rules adopted by the board. *[Because*
45 *of the special problems that may arise in individual instances under comprehensive group practice plan*

1 coverage involving acceptable physician-patient relations between a particular panel of physicians and
 2 particular eligible employees and their family members, the board shall provide a procedure under
 3 which any eligible employee may apply at any time to substitute a health service benefit plan for par-
 4 ticipation in a comprehensive group practice benefit plan.]

5 [(7)] (8) The board shall evaluate a **supplemental health** benefit plan that serves a limited ge-
 6 ographic region of this state according to the criteria described in subsection [(1)] (2) of this section.

7 **SECTION 17.** ORS 243.160 is amended to read:

8 243.160. A retired state officer or employee is not required to participate in one of the group
 9 benefit plans described in ORS 243.135 in order to obtain **supplemental** dental benefit plan cover-
 10 age. The Public Employees' Benefit Board shall establish by rule standards of eligibility for retired
 11 officers or employees to participate in a **supplemental** dental benefit plan.

12 **SECTION 18.** ORS 243.215 is amended to read:

13 243.215. Any eligible employee unable to participate in one or more of the plans described in
 14 ORS 243.135 [(1)] solely because the employee is assigned to perform duties outside the state may
 15 be eligible to receive the monthly state contribution, less administrative expenses, as payment of all
 16 or part of the cost of a [health] benefit plan of choice, subject to the approval of the Public
 17 Employees' Benefit Board and such rules as the board may adopt.

18 **SECTION 19.** ORS 243.275 is amended to read:

19 243.275. (1) [In addition to contracting for health and dental benefit plans,] The Public Employees'
 20 Benefit Board may contract with carriers to provide at the expense of participating eligible em-
 21 ployees and with or without state participation for coverage, including but not limited to, insurance
 22 or other benefit based on life, supplemental medical, supplemental dental, [optical] **vision**, accidental
 23 death or disability insurance plans.

24 (2) The monthly contribution of each eligible employee for other benefit plan or plans coverage,
 25 as described in subsection (1) of this section, shall be the total cost per month of the benefit cov-
 26 erage afforded the employee under the plan or plans, for which the employee exercises an option,
 27 including the cost of enrollment of such eligible employees and administrative expenses therefor.

28 (3) For any benefit plan or plans described in subsection (1) of this section in which the state
 29 participates, the monthly contribution of each eligible employee for the benefit plan, for which the
 30 employee exercises an option and there is state participation, shall be reduced by an amount equal
 31 to the portion thereof contributed by the state, including the cost of enrollment of the eligible em-
 32 ployee and the administrative expenses therefor.

33 (4) The board may withdraw approval of any such additional benefit plan coverage in the same
 34 manner as it withdraws approval of [health] benefit plans as described and authorized by ORS
 35 243.145.

36 (5) If any state agency contracts for any of the benefits described in subsection (1) of this sec-
 37 tion on behalf of any state employees, the administrative expenses thereof shall be paid by assess-
 38 ment of the participating employees. Such contracts are subject to approval of the board before they
 39 become operative. The board may withdraw approval for any such benefit in the same manner as it
 40 withdraws approval under ORS 243.145.

41
 42 **(Oregon Educators Benefit Board)**
 43

44 **SECTION 20.** ORS 243.860 is amended to read:

45 243.860. As used in ORS 243.860 to 243.886, unless the context requires otherwise:

1 (1) “Benefit plan” includes but is not limited to:

2 (a) Contracts for insurance or other benefits, including **supplemental** medical, dental[,] **or** vi-
 3 sion, life[,] **or** disability [*and other health care recognized by state law, and related services and sup-*
 4 *plies*]; **and**

5 [(b) *Self-insurance programs managed by the Oregon Educators Benefit Board; and*]

6 [(c) *Comparable benefits for employees who rely on spiritual means of healing*]

7 **(b) The Affordable Health Care for All Oregon Plan or comparable benefits for employees**
 8 **who rely on spiritual means of healing.**

9 (2) “Carrier” means an insurance company or health care service contractor holding a valid
 10 certificate of authority from the Director of the Department of Consumer and Business Services, or
 11 two or more companies or contractors acting together pursuant to a joint venture, partnership or
 12 other joint means of operation, or a board-approved provider or guarantor of benefit plan coverage
 13 and compensation.

14 (3) “District” means a common school district, a union high school district, an education service
 15 district, as defined in ORS 334.003, or a community college district, as defined in ORS 341.005.

16 (4)(a) “Eligible employee” includes:

17 (A) An officer or employee of a district who elects to participate in one of the benefit plans
 18 described in ORS 243.864 to 243.874; and

19 (B) An officer or employee of a district, whether or not retired, who:

20 (i) Is receiving a service retirement allowance, a disability retirement allowance or a pension
 21 under the Public Employees Retirement System or is receiving a service retirement allowance, a
 22 disability retirement allowance or a pension under any other retirement or disability benefit plan
 23 or system offered by the district for its officers and employees;

24 (ii) Is eligible to receive a service retirement allowance under the Public Employees Retirement
 25 System and has reached earliest service retirement age under ORS chapter 238;

26 (iii) Is eligible to receive a pension under ORS 238A.100 to 238A.245 and has reached earliest
 27 retirement age as described in ORS 238A.165; or

28 (iv) Is eligible to receive a service retirement allowance or pension under any other retirement
 29 benefit plan or system offered by the district and has attained earliest retirement age under the plan
 30 or system.

31 (b) Except as provided in paragraph (a)(B) of this subsection, “eligible employee” does not in-
 32 clude an individual:

33 (A) Engaged as an independent contractor;

34 (B) Whose periods of employment in emergency work are on an intermittent or irregular basis;
 35 or

36 (C) Who is employed on less than a half-time basis unless the individual is employed in a posi-
 37 tion classified as a job-sharing position or unless the individual is defined as eligible under rules of
 38 the Oregon Educators Benefit Board or under a collective bargaining agreement.

39 (5) “Family member” means an eligible employee’s spouse or domestic partner and any unmar-
 40 ried child or stepchild of an eligible employee within age limits and other conditions imposed by the
 41 Oregon Educators Benefit Board with regard to unmarried children or stepchildren.

42 (6) “Payroll disbursing officer” means the officer or official authorized to disburse moneys in
 43 payment of salaries and wages of officers and employees of a district.

44 (7) “Premium” means the monthly or other periodic charge, including administrative fees of the
 45 Oregon Educators Benefit Board, for a benefit plan.

SECTION 21. ORS 243.864 is amended to read:

243.864. (1) The Oregon Educators Benefit Board:

(a) Shall adopt rules for the conduct of its business and for carrying out ORS 243.879; and

(b) May adopt rules not inconsistent with ORS 243.860 to 243.886 to determine the terms and conditions of eligible employee participation in and coverage under benefit plans.

(2) The board shall study all matters connected with the provision of adequate benefit plan coverage for eligible employees on the best basis possible with regard to the welfare of the employees and affordability for the districts. The board shall design benefits, prepare specifications, analyze carrier responses to advertisements for bids and award contracts. Contracts shall be signed by the chairperson on behalf of the board.

(3) In carrying out its duties under subsections (1) and (2) of this section, the goal of the board is to provide high-quality *[health, dental and other]* benefit plans for eligible employees at a cost affordable to the districts, the employees and the taxpayers of Oregon.

(4) The board shall prepare specifications, invite bids and take actions necessary to award contracts for *[health and dental]* benefit plan coverage of eligible employees in accordance with the criteria set forth in ORS 243.866 *[(1)]* **(2)**. The Public Contracting Code does not apply to contracts for benefit plans provided under ORS 243.860 to 243.886. The board may not exclude from competition to contract for a benefit plan an Oregon carrier solely because the carrier does not serve all counties in Oregon.

(5) The board may retain consultants, brokers or other advisory personnel when necessary and shall employ such personnel as are required to perform the functions of the board.

SECTION 22. ORS 243.866 is amended to read:

243.866. (1) **Any person who is eligible to participate in a health benefit plan under ORS 243.860 to 243.886 shall enroll in the Affordable Health Care for All Oregon Plan.**

[(1)] **(2) If the Oregon Educators Benefit Board contracts for health benefit plans to supplement coverage provided in the Affordable Health Care for All Oregon Plan, the board shall contract for supplemental health benefit plans best designed to meet the needs and provide for the welfare of eligible employees and the districts. In considering whether to enter into a contract for a supplemental health benefit plan, the board shall place emphasis on:**

- (a) Employee choice among high-quality plans;
- (b) Encouragement of a competitive marketplace;
- (c) Plan performance and information;
- (d) District flexibility in plan design and contracting;
- (e) Quality customer service;
- (f) Creativity and innovation;
- (g) Plan benefits as part of total employee compensation; and
- (h) Improvement of employee health.

[(2)] **(3) The board may approve more than one carrier for each type of supplemental health benefit plan offered, but the board shall limit the number of carriers to a number consistent with adequate service to eligible employees and family members.**

[(3)] **(4) When appropriate, the board shall provide options under which an eligible employee may arrange coverage for family members under a supplemental health benefit plan.**

[(4)] **(5) A district shall provide that payroll deductions for supplemental health benefit plan costs that are not payable by the district may be made upon receipt of a signed authorization from the employee indicating an election to participate in the supplemental health benefit plan or plans**

1 selected and allowing the deduction of those costs from the employee's pay.

2 [(5)] (6) In developing any **supplemental health** benefit plan, the board may provide an option
3 of additional coverage for eligible employees and family members at an additional premium.

4 [(6)] (7) The board shall adopt rules providing that transfer of enrollment from one **supple-**
5 **mental health** benefit plan to another is open to all eligible employees and family members. [*Be-*
6 *cause of the special problems that may arise involving acceptable physician-patient relations between*
7 *a particular panel of physicians and a particular eligible employee or family member under a compre-*
8 *hensive group practice benefit plan, the board shall provide a procedure under which any eligible em-*
9 *ployee may apply at any time to substitute another benefit plan for participation in a comprehensive*
10 *group practice benefit plan.*]

11 [(7) *An eligible employee who is retired is not required to participate in a health benefit plan of-*
12 *fered under this section in order to obtain dental benefit plan coverage. The board shall establish by*
13 *rule standards of eligibility for retired employees to participate in a dental benefit plan.*]

14 (8) The board shall evaluate a **supplemental health** benefit plan that serves a limited ge-
15 ographic region of this state according to the criteria described in subsection [(1)] (2) of this section.

16 **SECTION 23.** ORS 243.868 is amended to read:

17 243.868. (1) [*In addition to contracting for health and dental benefit plans,*] The Oregon Educators
18 Benefit Board may contract with carriers to provide [*other*] benefit plans including, but not limited
19 to, insurance or other benefits based on life, supplemental medical, supplemental dental, supple-
20 mental vision, accidental death or disability insurance plans.

21 (2) The premium for each eligible employee for coverage under a benefit plan [*other than a*
22 *health or dental benefit plan*] described in subsection (1) of this section shall be the total cost per
23 month of the coverage afforded the employee under the plan for which the employee exercises an
24 option, including the cost of enrollment of the eligible employee and administrative expenses for the
25 plan.

26 (3) The board may withdraw approval of any additional benefit plan in the same manner as it
27 withdraws approval of a health or dental benefit plan as described and authorized by ORS 243.878.

28 (4) If the board does not contract for a benefit plan described in subsection (1) of this section,
29 a district may contract for the benefit plan on behalf of any district employees. The administrative
30 expenses of the plan shall be paid in accordance with the district's negotiated agreement with the
31 employees. Benefit plans entered into by a district are subject to approval by the board before they
32 become operative. The board may withdraw approval of any such benefit plan in the same manner
33 as it withdraws approval of a benefit plan under ORS 243.878.

34
35 **AFFORDABLE HEALTH CARE FOR ALL OREGON FUND**

36
37 **SECTION 24.** (1) **The Affordable Health Care for All Oregon Fund is established in the**
38 **State Treasury, separate and distinct from the General Fund, consisting of moneys received**
39 **under ORS 243.185 and 243.882 and sections 8, 26 and 27 of this 2013 Act, moneys appropriated**
40 **by the Legislative Assembly and moneys received from federal, state, county and local gov-**
41 **ernments and private sources to pay for health care services covered by the Affordable**
42 **Health Care for All Oregon Plan. Moneys in the Affordable Health Care for All Oregon Fund**
43 **are continuously appropriated to the Oregon Health Authority to administer the Affordable**
44 **Health Care for All Oregon Plan and to carry out ORS 442.315 and 442.325 and sections 1, 5,**
45 **7, 8, 9, 10, 26 and 27 of this 2013 Act.**

1 (2) The Affordable Health Care for All Oregon Reserve Account is established in the Af-
 2 ffordable Health Care for All Oregon Fund and consists of moneys transferred from the fund
 3 to the reserve account. The board shall determine the minimum and maximum amounts of
 4 moneys to be maintained in the reserve account.

5 (3) The Affordable Health Care for All Oregon Excess Funds Account is established in the
 6 Affordable Health Care for All Oregon Fund and consists of moneys transferred from the
 7 fund to the excess funds account under section 25 of this 2013 Act. Notwithstanding ORS
 8 293.190, any moneys remaining in the excess funds account at the end of a biennium that
 9 were appropriated from the General Fund do not revert to the General Fund.

10 **SECTION 25.** (1) Whenever the amount of moneys in the Affordable Health Care for All
 11 Oregon Fund exceeds the amount obligated for the remainder of the biennium, the Oregon
 12 Health Authority shall transfer the excess amount to the Affordable Health Care for All
 13 Oregon Excess Funds Account. Moneys in the excess funds account may be transferred to
 14 the fund as necessary to carry out the provisions specified in section 24 of this 2013 Act.

15 (2) The Affordable Health Care for All Oregon Board shall establish the maximum
 16 amount of moneys to be maintained in the excess funds account. Moneys in the excess funds
 17 account may be transferred to the Affordable Health Care for All Oregon Reserve Account.

18 **SECTION 26.** (1) The Affordable Health Care for All Oregon Plan shall be the primary
 19 payer of reimbursement for health services provided through the plan, including but not
 20 limited to compensable medical expenses covered by workers' compensation insurance.

21 (2) The Oregon Health Authority is subrogated to the rights of any person that has a
 22 claim against an insurer, tortfeasor, employer, third party administrator, pension manager,
 23 public or private corporation, government entity or any other person that may be liable for
 24 the cost of health services paid for by the Affordable Health Care for All Oregon Plan.

25 (3) The authority may enter into an agreement with any person for the prepayment of
 26 claims anticipated to arise under subsection (2) of this section during a biennium. At the end
 27 of the biennium, the authority shall appropriately charge or refund to the payer the differ-
 28 ence between the amount prepaid and the amount due.

29 (4) All moneys recovered pursuant to this section shall be deposited in the Affordable
 30 Health Care for All Oregon Fund established in section 24 of this 2013 Act.

31
 32 **FINANCING OF THE AFFORDABLE HEALTH CARE**
 33 **FOR ALL OREGON PLAN**
 34

35 **SECTION 27.** (1) The Affordable Health Care for All Oregon Board shall develop recom-
 36 mendations for dedicated funding mechanisms to finance the Affordable Health Care for All
 37 Oregon Plan. In lieu of premiums, copayments, coinsurance and deductibles, the plan must
 38 be funded by a system of dedicated, progressive taxes that are based on the payer's ability
 39 to pay. The board shall consider an employer payroll tax, a graduated personal income tax,
 40 a transaction tax on stocks and bonds, other taxes on unearned income, a progressive surtax
 41 on higher incomes, a progressive tax on gross business receipts divided by full-time equiv-
 42 alent employment and any other possible sources of funding. Funding sources must be as-
 43 sessed based on the capacity of the source to generate sufficient revenue to fund the plan
 44 and maintain an adequate reserve as specified by the board under section 24 (2) of this 2013
 45 Act. The burden of the assessments must be distributed according to ability to pay.

1 (2) The board shall report its recommendations to the appropriate committees of the
 2 Seventy-eighth Legislative Assembly in the 2015 regular session in the manner provided by
 3 ORS 192.245.

4
 5 **ABOLISHMENT OF OREGON MEDICAL**
 6 **INSURANCE POOL PROGRAM**
 7

8 **SECTION 28.** (1) The Oregon Medical Insurance Pool Board is abolished. On the operative
 9 date of this section, the tenure of office of the members of the Oregon Medical Insurance
 10 Pool Board ceases.

11 (2) All moneys remaining in the Oregon Medical Insurance Pool Account and the Tem-
 12 porary High Risk Pool Program Fund on the operative date of this section are transferred
 13 for deposit in the Affordable Health Care for All Oregon Fund.

14 **SECTION 29.** The abolishment of the Oregon Medical Insurance Pool Board by section
 15 28 of this 2013 Act does not affect any action, proceeding or prosecution involving or with
 16 respect to the duties, functions and powers of the board begun before and pending at the
 17 time of the abolishment, except that the Oregon Health Authority is substituted for the
 18 board in the action, proceeding or prosecution.

19 **SECTION 30.** (1) Nothing in sections 28 and 29 of this 2013 Act, the amendments to
 20 statutes and session law by sections 47 to 98 of this 2013 Act or the repeal of statutes and
 21 session law by section 100 of this 2013 Act relieves a person of a liability, duty or obligation
 22 accruing under or with respect to the duties, functions and powers of the Oregon Medical
 23 Insurance Pool Board that accrues before the operative date of section 28 of this 2013 Act.
 24 The Oregon Health Authority may undertake the collection or enforcement of any such li-
 25 ability, duty or obligation.

26 (2) The rights and obligations of the board legally incurred under contracts, leases and
 27 business transactions executed, entered into or begun before the operative date of section
 28 28 of this 2013 Act are transferred to the authority. For the purpose of succession to these
 29 rights and obligations, the Oregon Health Authority is a continuation of the board.

30 **SECTION 31.** The rules of the Oregon Medical Insurance Pool Board in effect on the op-
 31 erative date of section 28 of this 2013 Act continue in effect until superseded or repealed by
 32 rules of the Oregon Health Authority. References in rules of the board to the board or an
 33 officer or employee of the board are considered to be references to the authority or an offi-
 34 cer or employee of the authority.

35 **SECTION 32.** Whenever, in any uncodified law or resolution of the Legislative Assembly
 36 or in any rule, document, record or proceeding authorized by the Legislative Assembly, ref-
 37 erence is made to the Oregon Medical Insurance Pool Board or an officer or employee of the
 38 board, the reference is considered to be a reference to the Oregon Health Authority or an
 39 officer or employee of the authority.

40 **SECTION 33.** For the purpose of harmonizing and clarifying statutory law, the Legislative
 41 Counsel may substitute for words designating the “Oregon Medical Insurance Pool Board”
 42 or its officers, wherever they occur in statutory law, words designating the “Oregon Health
 43 Authority” or its officers.

44 **SECTION 34.** For the purpose of harmonizing and clarifying statutory law, the Legislative
 45 Counsel may substitute for words designating the “Oregon Medical Insurance Pool

1 Account” or “Temporary High Risk Pool Program Fund,” wherever they occur in statutory
 2 law, words designating the “Affordable Health Care for All Oregon Fund.”
 3

4 **ABOLISHMENT OF OFFICE OF**
 5 **PRIVATE HEALTH PARTNERSHIPS**
 6

7 **SECTION 35.** The Office of Private Health Partnerships is abolished. On the operative
 8 date of this section, the tenure of the Administrator of the Office of Private Health Part-
 9 nerships ceases.

10 **SECTION 36.** The abolishment of the Office of Private Health Partnerships by section 35
 11 of this 2013 Act does not affect any action, proceeding or prosecution involving or with re-
 12 spect to the duties, functions and powers of the office begun before and pending at the time
 13 of the abolishment, except that the Oregon Health Authority is substituted for the Office of
 14 Private Health Partnerships in the action, proceeding or prosecution.

15 **SECTION 37.** (1) Nothing in sections 35 and 36 of this 2013 Act, the amendments to
 16 statutes and session law by sections 47 to 98 of this 2013 Act or the repeal of statutes and
 17 session law by section 100 of this 2013 Act relieves a person of a liability, duty or obligation
 18 accruing under or with respect to the duties, functions and powers of the Office of Private
 19 Health Partnerships that accrues before the operative date of section 35 of this 2013 Act. The
 20 Oregon Health Authority may undertake the collection or enforcement of any such liability,
 21 duty or obligation.

22 (2) The rights and obligations of the Office of Private Health Partnerships legally in-
 23 curred under contracts, leases and business transactions executed, entered into or begun
 24 before the operative date of section 35 of this 2013 Act are transferred to the authority. For
 25 the purpose of succession to these rights and obligations, the Oregon Health Authority is a
 26 continuation of the office.

27 **SECTION 38.** The rules of the Office of Private Health Partnerships in effect on the op-
 28 erative date of section 35 of this 2013 Act continue in effect until superseded or repealed by
 29 rules of the Oregon Health Authority. References in rules of the office to the office or an
 30 administrator or employee of the office are considered to be references to the authority or
 31 an administrator or employee of the authority.

32 **SECTION 39.** Whenever, in any uncodified law or resolution of the Legislative Assembly
 33 or in any rule, document, record or proceeding authorized by the Legislative Assembly, ref-
 34 erence is made to the Office of Private Health Partnerships or to an administrator or em-
 35 ployee of the office, the reference is considered to be a reference to the Oregon Health
 36 Authority or an administrator or employee of the authority.

37 **SECTION 40.** For the purpose of harmonizing and clarifying statutory law, the Legislative
 38 Counsel may substitute for words designating the “Office of Private Health Partnerships”
 39 or its administrator, wherever they occur in statutory law, words designating the “Oregon
 40 Health Authority” or its director.

41 **ABOLISHMENT OF OREGON HEALTH INSURANCE EXCHANGE**
 42

43
 44 **SECTION 41.** The Oregon Health Insurance Exchange Corporation is abolished. On the
 45 operative date of this section, the tenure of the board of directors and the executive director

1 of the Oregon Health Insurance Exchange Corporation ceases.

2 **SECTION 42.** The abolishment of the Oregon Health Insurance Exchange Corporation by
 3 section 41 of this 2013 Act does not affect any action, proceeding or prosecution involving
 4 or with respect to the duties, functions and powers of the corporation begun before and
 5 pending at the time of the abolishment, except that the Oregon Health Authority is substi-
 6 tuted for the Oregon Health Insurance Exchange Corporation in the action, proceeding or
 7 prosecution.

8 **SECTION 43.** (1) Nothing in sections 41 and 42 of this 2013 Act, the amendments to
 9 statutes and session law by sections 47 to 98 of this 2013 Act or the repeal of statutes and
 10 session law by section 100 of this 2013 Act relieves a person of a liability, duty or obligation
 11 accruing under or with respect to the duties, functions and powers of the Oregon Health
 12 Insurance Exchange Corporation that accrues before the operative date of section 41 of this
 13 2013 Act. The Oregon Health Authority may undertake the collection or enforcement of any
 14 such liability, duty or obligation.

15 (2) The rights and obligations of the Oregon Health Insurance Exchange Corporation le-
 16 gally incurred under contracts, leases and business transactions executed, entered into or
 17 begun before the operative date of section 41 of this 2013 Act are transferred to the author-
 18 ity. For the purpose of succession to these rights and obligations, the Oregon Health Au-
 19 thority is a continuation of the corporation.

20 **SECTION 44.** The rules of the Oregon Health Insurance Exchange Corporation in effect
 21 on the operative date of section 41 of this 2013 Act continue in effect until superseded or
 22 repealed by rules of the Oregon Health Authority. References in rules of the corporation to
 23 the corporation or an administrator or employee of the corporation are considered to be
 24 references to the authority or an administrator or employee of the authority.

25 **SECTION 45.** Whenever, in any uncodified law or resolution of the Legislative Assembly
 26 or in any rule, document, record or proceeding authorized by the Legislative Assembly, ref-
 27 erence is made to the Oregon Health Insurance Exchange Corporation or to an administrator
 28 or employee of the corporation, the reference is considered to be a reference to the Oregon
 29 Health Authority or an administrator or employee of the authority.

30 **SECTION 46.** For the purpose of harmonizing and clarifying statutory law, the Legislative
 31 Counsel may substitute for words designating the “Oregon Health Insurance Exchange Cor-
 32 poration” or its executive director, wherever they occur in statutory law, words designating
 33 the “Oregon Health Authority” or its director.

34
 35 **CONFORMING AMENDMENTS**
 36

37 **SECTION 47.** ORS 65.957 is amended to read:

38 65.957. (1) This chapter applies to all domestic corporations in existence on October 3, 1989, that
 39 were incorporated under any general statute of this state providing for incorporation of nonprofit
 40 corporations if power to amend or repeal the statute under which the corporation was incorporated
 41 was reserved.

42 (2) Without limitation as to any other corporations that may be outside the scope of subsection
 43 (1) of this section, this chapter does not apply to the following:

44 (a) The Oregon State Bar and the Oregon State Bar Professional Liability Fund created under
 45 ORS 9.005 to 9.755;

1 (b) The State Accident Insurance Fund Corporation created under ORS chapter 656;

2 (c) The Oregon Insurance Guaranty Association and the Oregon Life and Health Insurance
3 Guaranty Association created under ORS chapter 734; and

4 (d) The Oregon FAIR Plan Association [*and the Oregon Medical Insurance Pool*] created under
5 ORS chapter 735.

6 **SECTION 48.** ORS 192.556 is amended to read:

7 192.556. As used in ORS 192.553 to 192.581:

8 (1) "Authorization" means a document written in plain language that contains at least the fol-
9 lowing:

10 (a) A description of the information to be used or disclosed that identifies the information in a
11 specific and meaningful way;

12 (b) The name or other specific identification of the person or persons authorized to make the
13 requested use or disclosure;

14 (c) The name or other specific identification of the person or persons to whom the covered entity
15 may make the requested use or disclosure;

16 (d) A description of each purpose of the requested use or disclosure, including but not limited
17 to a statement that the use or disclosure is at the request of the individual;

18 (e) An expiration date or an expiration event that relates to the individual or the purpose of the
19 use or disclosure;

20 (f) The signature of the individual or personal representative of the individual and the date;

21 (g) A description of the authority of the personal representative, if applicable; and

22 (h) Statements adequate to place the individual on notice of the following:

23 (A) The individual's right to revoke the authorization in writing;

24 (B) The exceptions to the right to revoke the authorization;

25 (C) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits
26 on whether the individual signs the authorization; and

27 (D) The potential for information disclosed pursuant to the authorization to be subject to
28 redisclosure by the recipient and no longer protected.

29 (2) "Covered entity" means:

30 (a) A state health plan;

31 (b) A health insurer;

32 (c) A health care provider that transmits any health information in electronic form to carry out
33 financial or administrative activities in connection with a transaction covered by ORS 192.553 to
34 192.581; or

35 (d) A health care clearinghouse.

36 (3) "Health care" means care, services or supplies related to the health of an individual.

37 (4) "Health care operations" includes but is not limited to:

38 (a) Quality assessment, accreditation, auditing and improvement activities;

39 (b) Case management and care coordination;

40 (c) Reviewing the competence, qualifications or performance of health care providers or health
41 insurers;

42 (d) Underwriting activities;

43 (e) Arranging for legal services;

44 (f) Business planning;

45 (g) Customer services;

- 1 (h) Resolving internal grievances;
- 2 (i) Creating deidentified information; and
- 3 (j) Fundraising.
- 4 (5) "Health care provider" includes but is not limited to:
- 5 (a) A psychologist, occupational therapist, regulated social worker, professional counselor or
- 6 marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675
- 7 or an employee of the psychologist, occupational therapist, regulated social worker, professional
- 8 counselor or marriage and family therapist;
- 9 (b) A physician, podiatric physician and surgeon, physician assistant or acupuncturist licensed
- 10 under ORS chapter 677 or an employee of the physician, podiatric physician and surgeon, physician
- 11 assistant or acupuncturist;
- 12 (c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of
- 13 the nurse or nursing home administrator;
- 14 (d) A dentist licensed under ORS chapter 679 or an employee of the dentist;
- 15 (e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental
- 16 hygienist or denturist;
- 17 (f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee
- 18 of the speech-language pathologist or audiologist;
- 19 (g) An emergency medical services provider licensed under ORS chapter 682;
- 20 (h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;
- 21 (i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic
- 22 physician;
- 23 (j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic
- 24 physician;
- 25 (k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage
- 26 therapist;
- 27 (L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct
- 28 entry midwife;
- 29 (m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical
- 30 therapist;
- 31 (n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical
- 32 imaging licensee;
- 33 (o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory
- 34 care practitioner;
- 35 (p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the poly-
- 36 somnographic technologist;
- 37 (q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;
- 38 (r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;
- 39 (s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral
- 40 service practitioner;
- 41 (t) A health care facility as defined in ORS 442.015;
- 42 (u) A home health agency as defined in ORS 443.005;
- 43 (v) A hospice program as defined in ORS 443.850;
- 44 (w) A clinical laboratory as defined in ORS 438.010;
- 45 (x) A pharmacy as defined in ORS 689.005;

- 1 (y) A diabetes self-management program as defined in ORS 743A.184; and
 2 (z) Any other person or entity that furnishes, bills for or is paid for health care in the normal
 3 course of business.
- 4 (6) “Health information” means any oral or written information in any form or medium that:
 5 (a) Is created or received by a covered entity, a public health authority, an employer, a life
 6 insurer, a school, a university or a health care provider that is not a covered entity; and
 7 (b) Relates to:
 8 (A) The past, present or future physical or mental health or condition of an individual;
 9 (B) The provision of health care to an individual; or
 10 (C) The past, present or future payment for the provision of health care to an individual.
- 11 (7) “Health insurer” means[:]
 12 [(a)] an insurer as defined in ORS 731.106 who offers:
 13 [(A)] (a) A health benefit plan as defined in ORS 743.730;
 14 [(B)] (b) A short term health insurance policy, the duration of which does not exceed six months
 15 including renewals;
 16 [(C)] (c) A student health insurance policy;
 17 [(D)] (d) A Medicare supplemental policy; or
 18 [(E)] (e) A dental only policy.
 19 [(b) *The Oregon Medical Insurance Pool operated by the Oregon Medical Insurance Pool Board*
 20 *under ORS 735.600 to 735.650.*]
- 21 (8) “Individually identifiable health information” means any oral or written health information
 22 in any form or medium that is:
 23 (a) Created or received by a covered entity, an employer or a health care provider that is not
 24 a covered entity; and
 25 (b) Identifiable to an individual, including demographic information that identifies the individual,
 26 or for which there is a reasonable basis to believe the information can be used to identify an indi-
 27 vidual, and that relates to:
 28 (A) The past, present or future physical or mental health or condition of an individual;
 29 (B) The provision of health care to an individual; or
 30 (C) The past, present or future payment for the provision of health care to an individual.
- 31 (9) “Payment” includes but is not limited to:
 32 (a) Efforts to obtain premiums or reimbursement;
 33 (b) Determining eligibility or coverage;
 34 (c) Billing activities;
 35 (d) Claims management;
 36 (e) Reviewing health care to determine medical necessity;
 37 (f) Utilization review; and
 38 (g) Disclosures to consumer reporting agencies.
- 39 (10) “Personal representative” includes but is not limited to:
 40 (a) A person appointed as a guardian under ORS 125.305, 419B.370, 419C.481 or 419C.555 with
 41 authority to make medical and health care decisions;
 42 (b) A person appointed as a health care representative under ORS 127.505 to 127.660 or a rep-
 43 resentative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment
 44 decisions;
 45 (c) A person appointed as a personal representative under ORS chapter 113; and

1 (d) A person described in ORS 192.573.

2 (11)(a) "Protected health information" means individually identifiable health information that is
3 maintained or transmitted in any form of electronic or other medium by a covered entity.

4 (b) "Protected health information" does not mean individually identifiable health information in:

5 (A) Education records covered by the federal Family Educational Rights and Privacy Act (20
6 U.S.C. 1232g);

7 (B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

8 (C) Employment records held by a covered entity in its role as employer.

9 (12) "State health plan" means:

10 (a) Medical assistance as defined in ORS 414.025;

11 (b) The Health Care for All Oregon Children program;

12 [(c) *The Family Health Insurance Assistance Program established in ORS 414.841 to 414.864; or]*

13 (c) **The Affordable Health Care for All Oregon Plan established by section 1 of this 2013
14 Act; or**

15 (d) Any medical assistance or premium assistance program operated by the Oregon Health Au-
16 thority **or the Department of Human Services.**

17 (13) "Treatment" includes but is not limited to:

18 (a) The provision, coordination or management of health care; and

19 (b) Consultations and referrals between health care providers.

20 **SECTION 49.** ORS 243.886, as amended by sections 9 and 13, chapter 38, Oregon Laws 2012, is
21 amended to read:

22 243.886. (1) Except as provided in subsections (2), (3) and (4) of this section, a district may not
23 provide or contract for a benefit plan and eligible employees of districts may not participate in a
24 benefit plan unless the benefit plan[:]

25 [(a)] is provided and administered by the Oregon Educators Benefit Board under ORS 243.860
26 to 243.886[; or]

27 [(b) *Is offered through the health insurance exchange under ORS 741.310 (1)(c).*]

28 (2)(a) Except for community college districts, a district that was self-insured before January 1,
29 2007, or a district that had an independent health insurance trust established and functioning before
30 January 1, 2007, may provide or contract for benefit plans other than benefit plans provided and
31 administered by the board if the premiums for the benefit plans provided or contracted for by the
32 district are equal to or less than the premiums for comparable benefit plans provided and adminis-
33 tered by the board.

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

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

42 (3)(a) A district that has not offered benefit plans provided and administered by the board before
43 June 23, 2009, may provide or contract for benefit plans other than benefit plans provided and ad-
44 ministered by the board if the premiums for the benefit plans provided or contracted for by the
45 district are equal to or less than the premiums for comparable benefit plans provided and adminis-

1 tered by the board. Once employees of a district or an employee group within a district participates
 2 in benefit plans provided and administered by the board, the district may not thereafter provide or
 3 contract for benefit plans for those employees or employee groups other than those provided and
 4 administered by the board.

5 (b) To maintain the exception created in this subsection, the board must perform an actuarial
 6 analysis of the district at least once every two years. If requested by the district or a labor organ-
 7 ization representing eligible employees of the district, the board shall perform the actuarial analysis
 8 annually.

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

10 (4) Nothing in ORS 243.860 to 243.886 may be construed to expand or contract collective bar-
 11 gaining rights or collective bargaining obligations.

12 **SECTION 50.** ORS 291.055 is amended to read:

13 291.055. (1) Notwithstanding any other law that grants to a state agency the authority to es-
 14 tablish fees, all new state agency fees or fee increases adopted during the period beginning on the
 15 date of adjournment sine die of a regular session of the Legislative Assembly and ending on the date
 16 of adjournment sine die of the next regular session of the Legislative Assembly:

17 (a) Are not effective for agencies in the executive department of government unless approved
 18 in writing by the Director of the Oregon Department of Administrative Services;

19 (b) Are not effective for agencies in the judicial department of government unless approved in
 20 writing by the Chief Justice of the Supreme Court;

21 (c) Are not effective for agencies in the legislative department of government unless approved
 22 in writing by the President of the Senate and the Speaker of the House of Representatives;

23 (d) Shall be reported by the state agency to the Oregon Department of Administrative Services
 24 within 10 days of their adoption; and

25 (e) Are rescinded on adjournment sine die of the next regular session of the Legislative Assem-
 26 bly as described in this subsection, unless otherwise authorized by enabling legislation setting forth
 27 the approved fees.

28 (2) This section does not apply to:

29 (a) Any tuition or fees charged by the State Board of Higher Education and the public univer-
 30 sities listed in ORS 352.002.

31 (b) Taxes or other payments made or collected from employers for unemployment insurance re-
 32 quired by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contri-
 33 butions and assessments calculated by cents per hour for workers' compensation coverage required
 34 by ORS 656.506.

35 (c) Fees or payments required for:

36 (A) Health care services provided by the Oregon Health and Science University, by the Oregon
 37 Veterans' Homes and by other state agencies and institutions pursuant to ORS 179.610 to 179.770.

38 *[(B) Assessments and premiums paid to the Oregon Medical Insurance Pool established by ORS*
 39 *735.614 and 735.625.]*

40 *[(C)]* (B) Copayments and premiums paid to the Oregon medical assistance program.

41 *[(D)]* (C) Assessments paid to the Department of Consumer and Business Services under ORS
 42 743.951 and 743.961.

43 (d) Fees created or authorized by statute that have no established rate or amount but are cal-
 44 culated for each separate instance for each fee payer and are based on actual cost of services pro-
 45 vided.

- 1 (e) State agency charges on employees for benefits and services.
- 2 (f) Any intergovernmental charges.
- 3 (g) Forest protection district assessment rates established by ORS 477.210 to 477.265 and the
- 4 Oregon Forest Land Protection Fund fees established by ORS 477.760.
- 5 (h) State Department of Energy assessments required by ORS 469.421 (8) and 469.681.
- 6 (i) Any charges established by the State Parks and Recreation Director in accordance with ORS
- 7 565.080 (3).
- 8 (j) Assessments on premiums charged by the Department of Consumer and Business Services
- 9 pursuant to ORS 731.804 or fees charged by the Division of Finance and Corporate Securities of the
- 10 Department of Consumer and Business Services to banks, trusts and credit unions pursuant to ORS
- 11 706.530 and 723.114.
- 12 (k) Public Utility Commission operating assessments required by ORS 756.310 or charges paid
- 13 to the Residential Service Protection Fund required by chapter 290, Oregon Laws 1987.
- 14 (L) Fees charged by the Housing and Community Services Department for intellectual property
- 15 pursuant to ORS 456.562.
- 16 (m) New or increased fees that are anticipated in the legislative budgeting process for an
- 17 agency, revenues from which are included, explicitly or implicitly, in the legislatively adopted
- 18 budget or the legislatively approved budget for the agency.
- 19 (n) Tolls approved by the Oregon Transportation Commission pursuant to ORS 383.004.
- 20 (o) Convenience fees as defined in ORS 182.126 and established by the Oregon Department of
- 21 Administrative Services under ORS 182.132 (3) and recommended by the Electronic Government
- 22 Portal Advisory Board.
- 23 (3)(a) Fees temporarily decreased for competitive or promotional reasons or because of unex-
- 24 pected and temporary revenue surpluses may be increased to not more than their prior level without
- 25 compliance with subsection (1) of this section if, at the time the fee is decreased, the state agency
- 26 specifies the following:
- 27 (A) The reason for the fee decrease; and
- 28 (B) The conditions under which the fee will be increased to not more than its prior level.
- 29 (b) Fees that are decreased for reasons other than those described in paragraph (a) of this sub-
- 30 section may not be subsequently increased except as allowed by ORS 291.050 to 291.060 and 294.160.
- 31 **SECTION 51.** ORS 411.402 is amended to read:
- 32 411.402. (1) The Department of Human Services and the Oregon Health Authority shall adopt
- 33 by rule the documentation required from each person applying for medical assistance, including
- 34 documentation of:
- 35 (a) The identity of the person;
- 36 (b) The category of aid that makes the person eligible for medical assistance or the way in
- 37 which the person qualifies as categorically needy;
- 38 (c) The status of the person as a resident of this state; and
- 39 (d) Information concerning the income and resources of the person, which may include income
- 40 tax return information and Social Security number, as necessary to establish financial eligibility for
- 41 medical assistance, premium tax credits and cost-sharing reductions.
- 42 (2) Information obtained by the department or the authority under this section may be ex-
- 43 changed with other state or federal agencies for the purpose of:
- 44 (a) Verifying eligibility for medical assistance[, *participation in the Oregon Health Insurance*
- 45 *Exchange*] or other health benefit programs;

1 (b) Establishing the amount of any tax credit due to the person, cost-sharing reduction or pre-
 2 mium assistance;

3 (c) Improving the provision of services; and

4 (d) Administering health benefit programs.

5 **SECTION 52.** ORS 413.011, as amended by section 15, chapter 38, Oregon Laws 2012, is
 6 amended to read:

7 413.011. (1) The duties of the Oregon Health Policy Board are to:

8 (a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS
 9 413.032 and all of the authority's departmental divisions.

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

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

14 *[(d)]* (b) Establish and continuously refine uniform, statewide health care quality standards for
 15 use by all purchasers of health care, third-party payers and health care providers as quality per-
 16 formance benchmarks.

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

19 *[(f)]* (d) Approve and monitor community-centered health initiatives described in ORS 413.032
 20 (1)(i) that are consistent with public health goals, strategies, programs and performance standards
 21 adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and shall reg-
 22 ularly report to the Legislative Assembly on the accomplishments and needed changes to the initi-
 23 atives.

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

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

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

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

32 *[(k)]* (h) By December 31 [2010] **of each year**, investigate and report to the Legislative
 33 Assembly[, and annually thereafter,] on the feasibility and advisability of future changes to the health
 34 insurance market in Oregon, including but not limited to the following:

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

36 *[(B) A payroll tax as a means to encourage employers to continue providing health insurance to*
 37 *their employees.]*

38 *[(C)]* (B) The implementation of a system of interoperable electronic health records utilized by
 39 all health care providers in this state.

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

45 *[(m)]* (j) Oversee the expenditure of moneys from the Health Care Workforce Strategic Fund to

1 support grants to primary care providers and rural health practitioners, to increase the number of
 2 primary care educators and to support efforts to create and develop career ladder opportunities.

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

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

8 (a) Subject to the approval of the Governor **and the Affordable Health Care for All Oregon**
 9 **Board established in section 5 of this 2013 Act**, organize and reorganize the authority as the
 10 **Oregon Health Policy Board** considers necessary to properly conduct the work of the authority.

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

16 (3) If the board or the authority is unable to perform, in whole or in part, any of the duties
 17 described in ORS 413.006 to 413.042[,] **and** 413.101 [*and 741.340*] without federal approval, the au-
 18 thority is authorized to request, in accordance with ORS 413.072, waivers or other approval neces-
 19 sary to perform those duties. The authority shall implement any portions of those duties not
 20 requiring legislative authority or federal approval, to the extent practicable.

21 (4) The enumeration of duties, functions and powers in this section is not intended to be exclu-
 22 sive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to
 23 413.042[,] **and** 413.101 [*and 741.340*] and by other statutes.

24 (5) The board shall consult with the Department of Consumer and Business Services in com-
 25 pleting the [*tasks*] **task** set forth in subsection [(1)(j) and (k)(A)] **(1)(h)(A)** of this section.

26 **SECTION 53.** ORS 413.017 is amended to read:

27 413.017. (1) The Oregon Health Policy Board shall establish the committees described in sub-
 28 sections (2) and (3) of this section.

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

31 (A) The Public Employees' Benefit Board.

32 (B) The Oregon Educators Benefit Board.

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

34 (D) A city government.

35 (E) A county government.

36 (F) A special district.

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

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

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

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

1 uniformity if practicable.

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

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

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

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

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

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

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

28 **SECTION 54.** ORS 413.032 is amended to read:

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

30 (a) Carry out policies adopted by the Oregon Health Policy Board **and the Affordable Health**
31 **Care for All Oregon Board;**

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

34 (c) Administer the Oregon Prescription Drug Program;

35 (d) Administer the Family Health Insurance Assistance Program;

36 (e) Develop the policies for and the provision of publicly funded medical care and medical as-
37 sistance in this state;

38 (f) Develop the policies for and the provision of mental health treatment and treatment of ad-
39 dictions;

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

41 (h) Provide regular reports to the **Oregon Health Policy** Board with respect to the performance
42 of health services contractors serving recipients of medical assistance, including reports of trends
43 in health services and enrollee satisfaction;

44 (i) Guide and support, with the authorization of the **Oregon Health Policy** Board, community-
45 centered health initiatives designed to address critical risk factors, especially those that contribute

1 to chronic disease;

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

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

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

7 (B) Approval of rates; and

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

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

14 (m) Guide and support community three-share agreements in which an employer, state or local
15 government and an individual all contribute a portion of a premium for a community-centered health
16 initiative or for insurance coverage;

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

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

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

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

26 (b) Develop uniform contracting standards for the purchase of health care, including the fol-
27 lowing:

28 (A) Uniform quality standards and performance measures;

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

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

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

34 (3) The enumeration of duties, functions and powers in this section is not intended to be exclu-
35 sive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Au-
36 thority by ORS 413.006 to 413.042, 413.101 and 741.340 **and section 10 of this 2013 Act** or by other
37 statutes.

38 **SECTION 55.** ORS 413.032, as amended by section 54 of this 2013 Act, is amended to read:

39 413.032. (1) The Oregon Health Authority is established. The authority shall:

40 (a) Carry out policies adopted by the Oregon Health Policy Board and the Affordable Health
41 Care for All Oregon Board;

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

44 (c) Administer the Oregon Prescription Drug Program;

45 [(d) Administer the Family Health Insurance Assistance Program;]

1 **(d) Implement and administer the Affordable Health Care for All Oregon Plan established**
 2 **in section 1 of this 2013 Act;**

3 (e) Develop the policies for and the provision of publicly funded medical care and medical as-
 4 sistance in this state;

5 (f) Develop the policies for and the provision of mental health treatment and treatment of ad-
 6 dictions;

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

8 (h) Provide regular reports to the Oregon Health Policy Board with respect to the performance
 9 of health services contractors serving recipients of medical assistance, including reports of trends
 10 in health services and enrollee satisfaction;

11 (i) Guide and support, with the authorization of the Oregon Health Policy Board, community-
 12 centered health initiatives designed to address critical risk factors, especially those that contribute
 13 to chronic disease;

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

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

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

19 (B) Approval of rates; and

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

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

26 (m) Guide and support community three-share agreements in which an employer, state or local
 27 government and an individual all contribute a portion of a premium for a community-centered health
 28 initiative or for insurance coverage;

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

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

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

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

38 (b) Develop uniform contracting standards for the purchase of health care, including the fol-
 39 lowing:

40 (A) Uniform quality standards and performance measures;

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

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

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

1 (3) The enumeration of duties, functions and powers in this section is not intended to be exclu-
2 sive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Au-
3 thority by ORS 413.006 to 413.042[,] **and** 413.101 [*and 741.340*] and section 10 of this 2013 Act or by
4 other statutes.

5 **SECTION 56.** ORS 413.037 is amended to read:

6 413.037. The Director of the Oregon Health Authority, each deputy director and authorized
7 representatives of the director may administer oaths, take depositions and issue subpoenas to compel
8 the attendance of witnesses and the production of documents or other written information necessary
9 to carry out the provisions of ORS 413.006 to 413.042[,] **and** 413.101 [*and 741.340*]. If any person fails
10 to comply with a subpoena issued under this section or refuses to testify on matters on which the
11 person lawfully may be interrogated, the director, deputy director or authorized representative may
12 follow the procedure set out in ORS 183.440 to compel obedience.

13 **SECTION 57.** ORS 413.201 is amended to read:

14 413.201. (1) The Oregon Health Authority is responsible for statewide outreach and marketing
15 of the Health Care for All Oregon Children program established in ORS 414.231 [*and administered*
16 *by the authority and the Office of Private Health Partnerships*] with the goal of enrolling [*in those*
17 *programs*] all eligible children residing in this state.

18 (2) To maximize the enrollment and retention of eligible children in the Health Care for All
19 Oregon Children program, the authority shall develop and administer a grant program to provide
20 funding to organizations and community based groups to deliver culturally specific and targeted
21 outreach and direct application assistance to:

22 (a) Members of racial, ethnic and language minority communities;

23 (b) Children living in geographic isolation; and

24 (c) Children and family members with additional barriers to accessing health care, such as cog-
25 nitive, mental health or sensory disorders, physical disabilities or chemical dependency, and children
26 experiencing homelessness.

27 **SECTION 58.** ORS 414.041 is amended to read:

28 414.041. (1) The Oregon Health Authority, under the direction of the Oregon Health Policy
29 Board and in collaboration with the Department of Human Services, shall implement a streamlined
30 and simple application process for the medical assistance [*and premium assistance programs*] **pro-**
31 **gram** administered by the Oregon Health Authority [*and the Office of Private Health Partnerships*].
32 The process shall include, but not be limited to:

33 (a) An online application that may be submitted via the Internet;

34 (b) Application forms that are readable at a sixth grade level and that request the minimum
35 amount of information necessary to begin processing the application; and

36 (c) Application assistance from qualified staff to aid individuals who have language, cognitive,
37 physical or geographic barriers to applying for medical assistance [*or premium assistance*].

38 (2) In developing the simplified application forms, the department shall consult with persons not
39 employed by the department who have experience in serving vulnerable and hard-to-reach popu-
40 lations.

41 (3) The Oregon Health Authority shall facilitate outreach and enrollment efforts to connect eli-
42 gible individuals with all available publicly funded health programs[, *including but not limited to the*
43 *Family Health Insurance Assistance Program*].

44 **SECTION 59.** ORS 414.231 is amended to read:

45 414.231. (1) As used in this section, "child" means a person under 19 years of age.

1 (2) The Health Care for All Oregon Children program is established to make affordable, acces-
2 sible health care available to all of Oregon's children. The program is composed of[:]

3 [(a)] medical assistance funded in whole or in part by Title XIX of the Social Security Act, by
4 the State Children's Health Insurance Program under Title XXI of the Social Security Act and by
5 moneys appropriated or allocated for that purpose by the Legislative Assembly.[: and]

6 [(b) *A private health option administered by the Office of Private Health Partnerships under ORS*
7 *414.826.*]

8 (3) A child is eligible for the program if the child is lawfully present in this state and the income
9 of the child's family is at or below 300 percent of the federal poverty guidelines. There is no asset
10 limit to qualify for the program.

11 (4)(a) A child receiving medical assistance under the program is continuously eligible for a
12 minimum period of 12 months.

13 (b) The Department of Human Services shall reenroll a child for successive 12-month periods of
14 enrollment as long as the child is eligible for medical assistance on the date of reenrollment.

15 (c) The department may not require a new application as a condition of reenrollment under
16 paragraph (b) of this subsection and must determine the child's eligibility for medical assistance
17 using information and sources available to the department or documentation readily available.

18 (5) Except for medical assistance funded by Title XIX of the Social Security Act, the department
19 or the Oregon Health Authority may prescribe by rule a period of uninsurance prior to enrollment
20 in the program.

21 **SECTION 60.** Section 1, chapter 867, Oregon Laws 2009, as amended by section 46, chapter 828,
22 Oregon Laws 2009, section 2, chapter 73, Oregon Laws 2010, and section 31, chapter 602, Oregon
23 Laws 2011, is amended to read:

24 **Sec. 1.** (1) The Health System Fund is established in the State Treasury, separate and distinct
25 from the General Fund. Interest earned by the Health System Fund shall be credited to the fund.

26 (2) Amounts in the Health System Fund are continuously appropriated to the Oregon Health
27 Authority for the purpose of funding the Health Care for All Oregon Children program established
28 in ORS 414.231, health services described in ORS 414.025 (8)(a) to (j) and other health services.
29 Moneys in the fund may also be used by the authority to:

30 (a) Provide grants to community health centers and safety net clinics under ORS 413.225.

31 (b) Pay refunds due under section 41, chapter 736, Oregon Laws 2003, and under section 11,
32 chapter 867, Oregon Laws 2009.

33 (c) Pay administrative costs incurred by the authority to administer the assessment in section
34 9, chapter 867, Oregon Laws 2009.

35 (d) Provide health services described in ORS 414.025 (8) to individuals described in ORS 414.025
36 (3)(f)(B).

37 [(3) *The authority shall develop a system for reimbursement by the authority to the Office of Private*
38 *Health Partnerships out of the Health System Fund for costs associated with administering the private*
39 *health option pursuant to ORS 414.826.*]

40 **SECTION 61.** ORS 430.315 is amended to read:

41 430.315. The Legislative Assembly finds alcoholism or drug dependence is an illness. The alco-
42 holic or drug-dependent person is ill and should be afforded treatment for that illness. To the
43 greatest extent possible, the least costly settings for treatment, outpatient services and residential
44 facilities shall be widely available and utilized except when contraindicated because of individual
45 health care needs. State agencies that purchase treatment for alcoholism or drug dependence shall

1 develop criteria consistent with this policy in consultation with the Oregon Health Authority. In
 2 *[reviewing applications for]* **developing policies and approving the adoption of rules for approv-**
 3 **ing a** certificate of need, the *[Director of the Oregon Health Authority]* **Affordable Health Care for**
 4 **All Oregon Board** shall take this policy into account.

5 **SECTION 62.** ORS 433.443 is amended to read:

6 433.443. (1) As used in this section:

7 (a) “Covered entity” means:

8 (A) The *[Children’s Health Insurance Program]* **Oregon Health Authority;**

9 (B) The *[Family Health Insurance Assistance Program established under ORS 414.842]* **Depart-**
 10 **ment of Human Services;**

11 (C) A health insurer that is an insurer as defined in ORS 731.106 and that issues health insur-
 12 ance as defined in ORS 731.162; **and**

13 *[(D) The state medical assistance program; and]*

14 *[(E)]* (D) A health care provider.

15 (b) “Health care provider” includes but is not limited to:

16 (A) A psychologist, occupational therapist, regulated social worker, professional counselor or
 17 marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675
 18 or an employee of the psychologist, occupational therapist, regulated social worker, professional
 19 counselor or marriage and family therapist;

20 (B) A physician, podiatric physician and surgeon, physician assistant or acupuncturist licensed
 21 under ORS chapter 677 or an employee of the physician, podiatric physician and surgeon, physician
 22 assistant or acupuncturist;

23 (C) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of
 24 the nurse or nursing home administrator;

25 (D) A dentist licensed under ORS chapter 679 or an employee of the dentist;

26 (E) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental
 27 hygienist or denturist;

28 (F) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee
 29 of the speech-language pathologist or audiologist;

30 (G) An emergency medical services provider licensed under ORS chapter 682;

31 (H) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

32 (I) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic
 33 physician;

34 (J) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic
 35 physician;

36 (K) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage
 37 therapist;

38 (L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct
 39 entry midwife;

40 (M) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical
 41 therapist;

42 (N) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical
 43 imaging licensee;

44 (O) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respir-
 45 atory care practitioner;

1 (P) A polysomnographic technologist licensed under ORS 688.819 or an employee of the poly-
2 somnographic technologist;

3 (Q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

4 (R) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;

5 (S) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral
6 service practitioner;

7 (T) A health care facility as defined in ORS 442.015;

8 (U) A home health agency as defined in ORS 443.005;

9 (V) A hospice program as defined in ORS 443.850;

10 (W) A clinical laboratory as defined in ORS 438.010;

11 (X) A pharmacy as defined in ORS 689.005;

12 (Y) A diabetes self-management program as defined in ORS 743A.184; and

13 (Z) Any other person or entity that furnishes, bills for or is paid for health care in the normal
14 course of business.

15 (c) "Individual" means a natural person.

16 (d) "Individually identifiable health information" means any oral or written health information
17 in any form or medium that is:

18 (A) Created or received by a covered entity, an employer or a health care provider that is not
19 a covered entity; and

20 (B) Identifiable to an individual, including demographic information that identifies the individual,
21 or for which there is a reasonable basis to believe the information can be used to identify an indi-
22 vidual, and that relates to:

23 (i) The past, present or future physical or mental health or condition of an individual;

24 (ii) The provision of health care to an individual; or

25 (iii) The past, present or future payment for the provision of health care to an individual.

26 (e) "Legal representative" means attorney at law, person holding a general power of attorney,
27 guardian, conservator or any person appointed by a court to manage the personal or financial affairs
28 of a person, or agency legally responsible for the welfare or support of a person.

29 (2)(a) During a public health emergency declared under ORS 433.441, the Public Health Director
30 may, as necessary to appropriately respond to the public health emergency:

31 (A) Adopt reporting requirements for and provide notice of those requirements to health care
32 providers, institutions and facilities for the purpose of obtaining information directly related to the
33 public health emergency;

34 (B) After consultation with appropriate medical experts, create and require the use of diagnostic
35 and treatment protocols to respond to the public health emergency and provide notice of those
36 protocols to health care providers, institutions and facilities;

37 (C) Order, or authorize local public health administrators to order, public health measures ap-
38 propriate to the public health threat presented;

39 (D) Upon approval of the Governor, take other actions necessary to address the public health
40 emergency and provide notice of those actions to health care providers, institutions and facilities,
41 including public health actions authorized by ORS 431.264;

42 (E) Take any enforcement action authorized by ORS 431.262, including the imposition of civil
43 penalties of up to \$500 per day against individuals, institutions or facilities that knowingly fail to
44 comply with requirements resulting from actions taken in accordance with the powers granted to
45 the Public Health Director under subparagraphs (A), (B) and (D) of this paragraph; and

1 (F) The authority granted to the Public Health Director under this section:

2 (i) Supersedes any authority granted to a local public health authority if the local public health
 3 authority acts in a manner inconsistent with guidelines established or rules adopted by the director
 4 under this section; and

5 (ii) Does not supersede the general authority granted to a local public health authority or a
 6 local public health administrator except as authorized by law or necessary to respond to a public
 7 health emergency.

8 (b) The authority of the Public Health Director to take administrative action, and the effec-
 9 tiveness of any action taken, under paragraph (a)(A), (B), (D), (E) and (F) of this subsection termi-
 10 nates upon the expiration of the proclaimed state of public health emergency, unless the actions are
 11 continued under other applicable law.

12 (3) Civil penalties under subsection (2) of this section shall be imposed in the manner provided
 13 in ORS 183.745. The Public Health Director must establish that the individual, institution or facility
 14 subject to the civil penalty had actual notice of the action taken that is the basis for the penalty.
 15 The maximum aggregate total for penalties that may be imposed against an individual, institution
 16 or facility under subsection (2) of this section is \$500 for each day of violation, regardless of the
 17 number of violations of subsection (2) of this section that occurred on each day of violation.

18 (4)(a) During a proclaimed state of public health emergency, the Public Health Director and lo-
 19 cal public health administrators shall be given immediate access to individually identifiable health
 20 information necessary to:

21 (A) Determine the causes of an illness related to the public health emergency;

22 (B) Identify persons at risk;

23 (C) Identify patterns of transmission;

24 (D) Provide treatment; and

25 (E) Take steps to control the disease.

26 (b) Individually identifiable health information accessed as provided by paragraph (a) of this
 27 subsection may not be used for conducting nonemergency epidemiologic research or to identify
 28 persons at risk for post-traumatic mental health problems, or for any other purpose except the pur-
 29 poses listed in paragraph (a) of this subsection.

30 (c) Individually identifiable health information obtained by the Public Health Director or local
 31 public health administrators under this subsection may not be disclosed without written authori-
 32 zation of the identified individual except:

33 (A) Directly to the individual who is the subject of the information or to the legal representative
 34 of that individual;

35 (B) To state, local or federal agencies authorized to receive such information by state or federal
 36 law;

37 (C) To identify or to determine the cause or manner of death of a deceased individual; or

38 (D) Directly to a health care provider for the evaluation or treatment of a condition that is the
 39 subject of a proclamation of a state of public health emergency issued under ORS 433.441.

40 (d) Upon expiration of the state of public health emergency, the Public Health Director or local
 41 public health administrators may not use or disclose any individually identifiable health information
 42 that has been obtained under this section. If a state of emergency that is related to the state of
 43 public health emergency has been declared under ORS 401.165, the Public Health Director and local
 44 public health administrators may continue to use any individually identifiable information obtained
 45 as provided under this section until termination of the state of emergency.

1 (5) All civil penalties recovered under this section shall be paid into the State Treasury and
2 credited to the General Fund and are available for general governmental expenses.

3 (6) The Public Health Director may request assistance in enforcing orders issued pursuant to
4 this section from state or local law enforcement authorities. If so requested by the Public Health
5 Director, state and local law enforcement authorities, to the extent resources are available, shall
6 assist in enforcing orders issued pursuant to this section.

7 (7) If the Oregon Health Authority adopts temporary rules to implement the provisions of this
8 section, the rules adopted are not subject to the provisions of ORS 183.335 (6)(a). The authority may
9 amend temporary rules adopted pursuant to this subsection as often as necessary to respond to the
10 public health emergency.

11 **SECTION 63.** ORS 705.145 is amended to read:

12 705.145. (1) There is created in the State Treasury a fund to be known as the Consumer and
13 Business Services Fund, separate and distinct from the General Fund. All moneys collected or re-
14 ceived by the Department of Consumer and Business Services, except moneys [*collected pursuant to*
15 *ORS 735.612 and those moneys required*] to be paid into the Workers' Benefit Fund, shall be paid into
16 the State Treasury and credited to the Consumer and Business Services Fund. Moneys in the fund
17 may be invested in the same manner as other state moneys and any interest earned shall be credited
18 to the fund.

19 (2) The department shall keep a record of all moneys deposited in the Consumer and Business
20 Services Fund that shall indicate, by separate account, the source from which the moneys are de-
21 rived, the interest earned and the activity or program against which any withdrawal is charged.

22 (3) If moneys credited to any one account are withdrawn, transferred or otherwise used for
23 purposes other than the program or activity for which the account is established, interest shall ac-
24 crue on the amount withdrawn from the date of withdrawal and until such funds are restored.

25 (4) Moneys in the fund are continuously appropriated to the department for its administrative
26 expenses and for its expenses in carrying out its functions and duties under any provision of law.

27 (5) Except as provided in ORS 705.165, it is the intention of the Legislative Assembly that the
28 performance of the various duties and functions of the department in connection with each of its
29 programs shall be financed by the fees, assessments and charges established and collected in con-
30 nection with those programs.

31 (6) There is created by transfer from the Consumer and Business Services Fund a revolving ad-
32 ministrative account in the amount of \$100,000. The revolving account shall be disbursed by checks
33 or orders issued by the director or the Workers' Compensation Board and drawn upon the State
34 Treasury, to carry on the duties and functions of the department and the board. All checks or orders
35 paid from the revolving account shall be reimbursed by a warrant drawn in favor of the department
36 charged against the Consumer and Business Services Fund and recorded in the appropriate subsid-
37 iary record.

38 (7) For the purposes of ORS chapter 656, the revolving account created pursuant to subsection
39 (6) of this section may also be used to:

40 (a) Pay compensation benefits; and

41 (b) Refund to employers amounts paid to the Consumer and Business Services Fund in excess
42 of the amounts required by ORS chapter 656.

43 (8) Notwithstanding subsections (2), (3) and (5) of this section and except as provided in ORS
44 455.220 (1), the moneys derived pursuant to ORS 446.003 to 446.200, 446.210, 446.225 to 446.285,
45 446.395 to 446.420, 446.566 to 446.646, 446.661 to 446.756 and 455.220 (1) and deposited to the fund,

1 interest earned on those moneys and withdrawals of moneys for activities or programs under ORS
2 446.003 to 446.200, 446.210, 446.225 to 446.285, 446.395 to 446.420, 446.566 to 446.646 and 446.661 to
3 446.756, or education and training programs pertaining thereto, must be assigned to a single account
4 within the fund.

5 (9) Notwithstanding subsections (2), (3) and (5) of this section, the moneys derived pursuant to
6 ORS 455.240 or 460.370 or from state building code or specialty code program fees for which the
7 amount is established by department rule pursuant to ORS 455.020 (2) and deposited to the fund,
8 interest earned on those moneys and withdrawals of moneys for activities or programs described
9 under ORS 455.240 or 446.566 to 446.646, 446.661 to 446.756 and 460.310 to 460.370, structural or
10 mechanical specialty code programs or activities for which a fee is collected under ORS 455.020 (2),
11 or programs described under subsection (10) of this section that provide training and education for
12 persons employed in producing, selling, installing, delivering or inspecting manufactured structures
13 or manufactured dwelling parks or recreation parks, must be assigned to a single account within the
14 fund.

15 (10) Notwithstanding ORS 279.835 to 279.855 and ORS chapters 279A and 279B, the department
16 may, after consultation with the appropriate specialty code advisory boards established under ORS
17 455.132, 455.135, 455.138, 480.535 and 693.115, contract for public or private parties to develop or
18 provide training and education programs relating to the state building code and associated licensing
19 or certification programs.

20 **SECTION 64.** ORS 731.036 is amended to read:

21 731.036. Except as provided in ORS 743.061 or as specifically provided by law, the Insurance
22 Code does not apply to any of the following to the extent of the subject matter of the exemption:

23 (1) A bail bondsman, other than a corporate surety and its agents.

24 (2) A fraternal benefit society that has maintained lodges in this state and other states for 50
25 years prior to January 1, 1961, and for which a certificate of authority was not required on that
26 date.

27 (3) A religious organization providing insurance benefits only to its employees, if the organiza-
28 tion is in existence and exempt from taxation under section 501(c)(3) of the federal Internal Revenue
29 Code on September 13, 1975.

30 (4) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-
31 insurance program for tort liability in accordance with ORS 30.282.

32 (5) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-
33 insurance program for property damage in accordance with ORS 30.282.

34 (6) Cities, counties, school districts, community college districts, community college service dis-
35 tricts or districts, as defined in ORS 198.010 and 198.180, that either individually or jointly insure
36 for **supplemental** health insurance coverage, excluding disability insurance, their employees or re-
37 tired employees, or their dependents, or students engaged in school activities, or combination of
38 employees and dependents, with or without employee or student contributions, if all of the following
39 conditions are met:

40 (a) The individual or jointly self-insured program meets the following minimum requirements:

41 (A) In the case of a school district, community college district or community college service
42 district, the number of covered employees and dependents and retired employees and dependents
43 aggregates at least 500 individuals;

44 (B) In the case of an individual public body program other than a school district, community
45 college district or community college service district, the number of covered employees and depen-

1 dents and retired employees and dependents aggregates at least 500 individuals; and

2 (C) In the case of a joint program of two or more public bodies, the number of covered em-
3 ployees and dependents and retired employees and dependents aggregates at least 1,000 individuals;

4 (b) The individual or jointly self-insured **supplemental** health insurance program includes all
5 coverages and benefits required of group health insurance policies under ORS chapters 743 and
6 743A;

7 (c) The individual or jointly self-insured program must have program documents that define
8 program benefits and administration;

9 (d) Enrollees must be provided copies of summary plan descriptions including:

10 (A) Written general information about services provided, access to services, charges and sched-
11 uling applicable to each enrollee's coverage;

12 (B) The program's grievance and appeal process; and

13 (C) Other group health plan enrollee rights, disclosure or written procedure requirements es-
14 tablished under ORS chapters 743 and 743A;

15 (e) The financial administration of an individual or jointly self-insured program must include the
16 following requirements:

17 (A) Program contributions and reserves must be held in separate accounts and used for the ex-
18 clusive benefit of the program;

19 (B) The program must maintain adequate reserves. Reserves may be invested in accordance with
20 the provisions of ORS chapter 293. Reserve adequacy must be calculated annually with proper
21 actuarial calculations including the following:

22 (i) Known claims, paid and outstanding;

23 (ii) A history of incurred but not reported claims;

24 (iii) Claims handling expenses;

25 (iv) Unearned contributions; and

26 (v) A claims trend factor; and

27 (C) The program must maintain adequate reinsurance against the risk of economic loss in ac-
28 cordance with the provisions of ORS 742.065 unless the program has received written approval for
29 an alternative arrangement for protection against economic loss from the Director of the Depart-
30 ment of Consumer and Business Services;

31 (f) The individual or jointly self-insured program must have sufficient personnel to service the
32 employee benefit program or must contract with a third party administrator licensed under ORS
33 chapter 744 as a third party administrator to provide such services;

34 [(g) *The individual or jointly self-insured program shall be subject to assessment in accordance*
35 *with ORS 735.614 and former enrollees shall be eligible for portability coverage in accordance with*
36 *ORS 735.616;*]

37 [(h)] (g) The public body, or the program administrator in the case of a joint insurance program
38 of two or more public bodies, files with the Director of the Department of Consumer and Business
39 Services copies of all documents creating and governing the program, all forms used to communicate
40 the coverage to beneficiaries, the schedule of payments established to support the program and,
41 annually, a financial report showing the total incurred cost of the program for the preceding year.
42 A copy of the annual audit required by ORS 297.425 may be used to satisfy the financial report filing
43 requirement; and

44 [(i)] (h) Each public body in a joint insurance program is liable only to its own employees and
45 no others for benefits under the program in the event, and to the extent, that no further funds, in-

cluding funds from insurance policies obtained by the pool, are available in the joint insurance pool.

(7) All ambulance services.

(8) A person providing any of the services described in this subsection. The exemption under this subsection does not apply to an authorized insurer providing such services under an insurance policy. This subsection applies to the following services:

(a) Towing service.

(b) Emergency road service, which means adjustment, repair or replacement of the equipment, tires or mechanical parts of a motor vehicle in order to permit the motor vehicle to be operated under its own power.

(c) Transportation and arrangements for the transportation of human remains, including all necessary and appropriate preparations for and actual transportation provided to return a decedent's remains from the decedent's place of death to a location designated by a person with valid legal authority under ORS 97.130.

(9)(a) A person described in this subsection who, in an agreement to lease or to finance the purchase of a motor vehicle, agrees to waive for no additional charge the amount specified in paragraph (b) of this subsection upon total loss of the motor vehicle because of physical damage, theft or other occurrence, as specified in the agreement. The exemption established in this subsection applies to the following persons:

(A) The seller of the motor vehicle, if the sale is made pursuant to a motor vehicle retail installment contract.

(B) The lessor of the motor vehicle.

(C) The lender who finances the purchase of the motor vehicle.

(D) The assignee of a person described in this paragraph.

(b) The amount waived pursuant to the agreement shall be the difference, or portion thereof, between the amount received by the seller, lessor, lender or assignee, as applicable, that represents the actual cash value of the motor vehicle at the date of loss, and the amount owed under the agreement.

(10) A self-insurance program for tort liability or property damage that is established by two or more affordable housing entities and that complies with the same requirements that public bodies must meet under ORS 30.282 (6). As used in this subsection:

(a) "Affordable housing" means housing projects in which some of the dwelling units may be purchased or rented, with or without government assistance, on a basis that is affordable to individuals of low income.

(b) "Affordable housing entity" means any of the following:

(A) A housing authority created under the laws of this state or another jurisdiction and any agency or instrumentality of a housing authority, including but not limited to a legal entity created to conduct a self-insurance program for housing authorities that complies with ORS 30.282 (6).

(B) A nonprofit corporation that is engaged in providing affordable housing.

(C) A partnership or limited liability company that is engaged in providing affordable housing and that is affiliated with a housing authority described in subparagraph (A) of this paragraph or a nonprofit corporation described in subparagraph (B) of this paragraph if the housing authority or nonprofit corporation:

(i) Has, or has the right to acquire, a financial or ownership interest in the partnership or limited liability company;

(ii) Has the power to direct the management or policies of the partnership or limited liability

1 company;

2 (iii) Has entered into a contract to lease, manage or operate the affordable housing owned by
3 the partnership or limited liability company; or

4 (iv) Has any other material relationship with the partnership or limited liability company.

5 (11) A community-based health care initiative approved by the Administrator of the Office for
6 Oregon Health Policy and Research under ORS 735.723 operating a community-based health care
7 improvement program approved by the administrator.

8 (12) Except as provided in ORS 735.500 and 735.510, a person certified by the Department of
9 Consumer and Business Services to operate a retainer medical practice.

10 **SECTION 65.** ORS 734.790 is amended to read:

11 734.790. (1) ORS 734.750 to 734.890 provide coverage for policies and contracts specified in sub-
12 section (2) of this section to the following persons who are not provided coverage under the laws
13 of another state:

14 (a) To a person who is a resident, if the person is an owner of or a certificate holder under the
15 policy or contract other than a structured settlement annuity or, in the case of an unallocated an-
16 nuity contract, an employee participating in a governmental retirement plan established under sec-
17 tion 401, 403(b) or 457 of the United States Internal Revenue Code or the beneficiaries of each such
18 individual if deceased.

19 (b) To a person who is not a resident, if the person is an owner of or a certificate holder under
20 the policy or contract other than a structured settlement annuity or, in the case of an unallocated
21 annuity contract, an employee participating in a governmental retirement plan established under
22 section 401, 403(b) or 457 of the United States Internal Revenue Code or the beneficiaries of each
23 such individual if deceased. This paragraph applies to a person who is not a resident only if all of
24 the following conditions are met:

25 (A) The insurer that issued the policy or contract must be a member insurer.

26 (B) The state in which the person resides must have an association similar to the Oregon Life
27 and Health Insurance Guaranty Association.

28 (C) The person must not be eligible for coverage by an association in the state in which the
29 person resides, as described in subparagraph (B) of this paragraph, due to the fact that the insurer
30 was not authorized to transact insurance or licensed in that state at the time specified in the state's
31 guaranty association law.

32 (c) To a person who, regardless of where the person resides, is a beneficiary, assignee or payee
33 of the persons covered under paragraph (a) or (b) of this subsection. This paragraph does not include
34 a nonresident certificate holder under a group policy or contract.

35 (d) To a person who is a payee under a structured settlement annuity, or to the beneficiary of
36 a payee if the payee is deceased, if the payee:

37 (A) Is a resident, regardless of where the contract owner resides; or

38 (B) Is not a resident, but only under both of the following conditions:

39 (i) The contract owner of the structured settlement annuity is a resident and is not afforded any
40 coverage by an association in another state that is similar to the association created under ORS
41 734.800, or the contract owner of the structured settlement annuity is not a resident but the insurer
42 that issued the structured settlement annuity is domiciled in this state and the state in which the
43 contract owner resides has an association similar to the association created under ORS 734.800; and

44 (ii) Neither the payee or beneficiary nor the contract owner of the structured settlement annuity
45 is eligible for coverage by the association of the state in which the payee or contract owner resides.

1 (2) Except as limited by ORS 734.750 to 734.890, the association shall provide coverage to the
2 persons specified in subsection (1) of this section for direct nongroup life or health insurance poli-
3 cies or annuity contracts, for certificates under direct group policies or contracts, and for supple-
4 mental contracts to any of these, in each case issued by member insurers.

5 (3) ORS 734.750 to 734.890 do not provide coverage for:

6 (a) That portion of any policy or contract not guaranteed by the member insurer or under which
7 the risk is borne by the policyholder or contract owner.

8 (b) Any policy or contract or part thereof assumed by the impaired or insolvent insurer under
9 a contract of reinsurance, other than reinsurance for which assumption certificates have been is-
10 sued.

11 (c) Any policy or contract issued by a health care service contractor complying with ORS
12 750.005 to 750.095.

13 (d) Any policy or contract issued by a fraternal benefit society.

14 (e) Any portion of a policy or contract to the extent that the interest rate on which the policy
15 or contract is based, or to the extent that the interest rate, crediting rate or similar factor deter-
16 mined by use of an index or other external reference stated in the policy or contract for the purpose
17 of calculating returns or changes in value:

18 (A) Exceeds, when averaged over the period of four years prior to the date on which the member
19 insurer becomes either an impaired or insolvent insurer under ORS 734.750 to 734.890, whichever
20 occurs first, a rate of interest determined by subtracting four percentage points from Moody's Cor-
21 porate Bond Yield Average averaged for that same four-year period or for a lesser period if the
22 policy or contract was issued less than four years before the member insurer becomes either an
23 impaired or insolvent insurer under ORS 734.750 to 734.890, whichever occurred first; and

24 (B) Exceeds, on and after the date on which the member insurer becomes either an impaired or
25 insolvent insurer under ORS 734.750 to 734.890, whichever occurs first, the rate of interest deter-
26 mined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most
27 recently available.

28 (f) Any portion of a policy or contract issued to a plan or program of an employer, association
29 or similar entity to provide life insurance, health insurance or annuity benefits to its employees or
30 members to the extent that the plan or program is self-funded or uninsured, including benefits pay-
31 able by an employer, association or similar entity under any of the following:

32 (A) A multiple employer welfare arrangement as defined in section 3(40) (29 U.S.C. 1002(40)) of
33 the Employee Retirement Income Security Act of 1974, as amended.

34 (B) A minimum premium group insurance plan.

35 (C) A stop-loss group insurance plan.

36 (D) An administrative services only contract.

37 (g) Any portion of a policy or contract to the extent that it provides dividends or experience
38 rating credits or voting rights, or provides that any fees or allowances be paid to any person, in-
39 cluding the policyholder or contract owner, in connection with the service to or administration of
40 the policy or contract.

41 (h) Any policy or contract issued in this state by a member insurer at a time that the insurer
42 did not have a certificate of authority to issue the policy or contract in this state.

43 (i) Any unallocated annuity contract issued to or in connection with an employee benefit plan
44 protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal
45 Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to

1 the benefit plan.

2 (j) Any portion of any unallocated annuity contract that is not issued to or in connection with
3 a government retirement plan referred to in subsection (1) of this section, or a government lottery.

4 *[(k) Any coverage issued by the Oregon Medical Insurance Pool.]*

5 *[(L)]* (k) Any portion of a policy or contract to the extent that the assessments required by ORS
6 734.815 with respect to the policy or contract are preempted by federal or state law.

7 *[(m)]* (L) An obligation that does not arise under the express written terms of the policy or
8 contract issued by the insurer to the policyholder or contract owner, including but not limited to:

9 (A) Claims based on marketing materials;

10 (B) Claims based on side letters, riders or other documents that were issued by the insurer
11 without meeting applicable policy or contract form filing or approval requirements;

12 (C) Misrepresentations of, or regarding, policy or contract benefits;

13 (D) Extracontractual claims, including but not limited to claims related to bad faith in the pay-
14 ment of claims, punitive or exemplary damages or attorney fees or costs; or

15 (E) A claim for penalties or consequential or incidental damages.

16 *[(n)]* (m) A contractual agreement that establishes the member insurer's obligations to provide
17 a book value accounting guaranty for defined contribution benefit plan participants by reference to
18 a portfolio of assets that is owned by the benefit plan or its trustee that in either case is not an
19 affiliate of the member insurer.

20 *[(o)]* (n) Any portion of a policy or contract to the extent that portion provides for interest or
21 other changes in value to be determined by the use of an index or other external reference stated
22 in the policy or contract, but the changes in value have not been credited to the policy or contract,
23 or as to which the policyholder's or contract owner's rights are subject to forfeiture, as of the date
24 on which the member insurer becomes either an impaired or insolvent insurer, whichever occurs
25 first. If the interest or changes in value in a policy or contract are credited less frequently than
26 annually, for purposes of determining the values that have been credited and are not subject to
27 forfeiture under this paragraph, the interest or change in value that is determined by using the
28 procedures specified in the policy or contract shall be credited as if the contractual date of crediting
29 interest or changing value was the date of the impairment or insolvency, whichever is earlier, and
30 may not be subject to forfeiture.

31 *[(p)]* (o) Any policy or contract providing any hospital, medical, prescription drug or other
32 health care benefits under Part C or Part D of subchapter XVIII, chapter 7, Title 42 of the United
33 States Code, or any regulations issued under those provisions.

34 (4) As used in this section, "Moody's Corporate Bond Yield Average" means the Monthly Av-
35 erage Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

36 **SECTION 66.** ORS 743.402 is amended to read:

37 743.402. Nothing in ORS 743.405 to 743.498, 743A.160 and 743A.164 shall apply to or affect:

38 (1) Any workers' compensation insurance policy or any liability insurance policy with or without
39 supplementary expense coverage therein;

40 (2) Any policy of reinsurance;

41 (3) Any blanket or group policy of insurance; or

42 (4) Any life insurance policy, or policy supplemental thereto which contains only such provisions
43 relating to health insurance as:

44 (a) Provide additional benefits in case of death or dismemberment or loss of sight by accident;

45 or

1 (b) Operate to safeguard such policy against lapse, or to give a special surrender value or spe-
 2 cial benefit or an annuity in the event the insured shall become totally and permanently disabled,
 3 as defined by the policy or supplemental policy.

4 [(5) Coverage under ORS 735.600 to 735.650.]

5 **SECTION 67.** ORS 743.730, as amended by section 49, chapter 500, Oregon Laws 2011, and
 6 section 20, chapter 38, Oregon Laws 2012, is amended to read:

7 743.730. For purposes of ORS 743.730 to 743.773:

8 (1) "Actuarial certification" means a written statement by a member of the American Academy
 9 of Actuaries or other individual acceptable to the Director of the Department of Consumer and
 10 Business Services that a carrier is in compliance with the provisions of ORS 743.736, 743.760 or
 11 743.761, based upon the person's examination, including a review of the appropriate records and of
 12 the actuarial assumptions and methods used by the carrier in establishing premium rates for small
 13 employer and portability health benefit plans.

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

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

20 (a) That is applied uniformly and without regard to any health status related factors to an
 21 enrollee or late enrollee in lieu of a preexisting condition exclusion;

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

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

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

27 [(4) "Basic health benefit plan" means a health benefit plan that provides bronze plan coverage and
 28 that is approved by the Department of Consumer and Business Services under ORS 743.736.]

29 [(5)] (4) "Bona fide association" means an association that meets the requirements of 42 U.S.C.
 30 300gg-91 as amended and in effect on March 23, 2010.

31 [(6) "Bronze plan" means a health benefit plan that meets the criteria for a bronze plan prescribed
 32 by the director by rule pursuant to ORS 743.822 (2).]

33 [(7)] (5) "Carrier," except as provided in ORS 743.760, means any person who provides health
 34 benefit plans in this state, including:

35 (a) A licensed insurance company;

36 (b) A health care service contractor;

37 (c) A health maintenance organization;

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

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

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

43 (e) Any other person or corporation responsible for the payment of benefits or provision of ser-
 44 vices.

45 [(8) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic

1 *plan under 42 U.S.C. 18022(e) and that is offered through the Oregon Health Insurance Exchange.]*

2 [(9)] (6) “Creditable coverage” means prior health care coverage as defined in 42 U.S.C. 300gg
3 as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time
4 the enrollee obtains new coverage.

5 [(10)] (7) “Dependent” means the spouse or child of an eligible employee, subject to applicable
6 terms of the health benefit plan covering the employee.

7 [(11)] (8) “Eligible employee” means an employee who works on a regularly scheduled basis, with
8 a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility
9 between 17.5 and 40 hours per week subject to rules of the carrier. “Eligible employee” does not
10 include employees who work on a temporary, seasonal or substitute basis. Employees who have been
11 employed by the employer for fewer than 90 days are not eligible employees unless the employer so
12 allows.

13 [(12)] (9) “Employee” means any individual employed by an employer.

14 [(13)] (10) “Enrollee” means an employee, dependent of the employee or an individual otherwise
15 eligible for a group, individual or portability health benefit plan who has enrolled for coverage under
16 the terms of the plan.

17 [(14) “Exchange” means the health insurance exchange administered by the Oregon Health Insur-
18 ance Exchange Corporation in accordance with ORS 741.310.]

19 [(15)] (11) “Exclusion period” means a period during which specified treatments or services are
20 excluded from coverage.

21 [(16)] (12) “Financial impairment” means that a carrier is not insolvent and is:

- 22 (a) Considered by the director to be potentially unable to fulfill its contractual obligations; or
- 23 (b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

24 [(17)(a)] (13)(a) “Geographic average rate” means the arithmetical average of the lowest pre-
25 mium and the corresponding highest premium to be charged by a carrier in a geographic area es-
26 tablished by the director for the carrier’s:

- 27 (A) Group health benefit plans offered to small employers;
- 28 (B) Individual health benefit plans; or
- 29 (C) Portability health benefit plans.

30 (b) “Geographic average rate” does not include premium differences that are due to differences
31 in benefit design or family composition.

32 [(18)] (14) “Grandfathered health plan” has the meaning prescribed by the United States Secre-
33 taries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

34 [(19)] (15) “Group eligibility waiting period” means, with respect to a group health benefit plan,
35 the period of employment or membership with the group that a prospective enrollee must complete
36 before plan coverage begins.

37 [(20)(a)] (16)(a) “Health benefit plan” means any:

- 38 (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;
- 39 (B) Health care service contractor or health maintenance organization subscriber contract; or
- 40 (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-

41 ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the
42 extent that the plan is subject to state regulation.

43 (b) “Health benefit plan” does not include:

- 44 (A) Coverage for accident only, specific disease or condition only, credit or disability income;
- 45 (B) Coverage of Medicare services pursuant to contracts with the federal government;

- 1 (C) Medicare supplement insurance policies;
- 2 (D) Coverage of TRICARE services pursuant to contracts with the federal government;
- 3 (E) Benefits delivered through a flexible spending arrangement established pursuant to section
- 4 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition
- 5 to a group health benefit plan;
- 6 (F) Separately offered long term care insurance, including, but not limited to, coverage of nurs-
- 7 ing home care, home health care and community-based care;
- 8 (G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity in-
- 9 surance;
- 10 (H) Short term health insurance policies that are in effect for periods of 12 months or less, in-
- 11 cluding the term of a renewal of the policy;
- 12 (I) Dental only coverage;
- 13 (J) Vision only coverage;
- 14 (K) Stop-loss coverage that meets the requirements of ORS 742.065;
- 15 (L) Coverage issued as a supplement to liability insurance;
- 16 (M) Insurance arising out of a workers' compensation or similar law;
- 17 (N) Automobile medical payment insurance or insurance under which benefits are payable with
- 18 or without regard to fault and that is statutorily required to be contained in any liability insurance
- 19 policy or equivalent self-insurance; *[or]*
- 20 (O) Any employee welfare benefit plan that is exempt from state regulation because of the fed-
- 21 eral Employee Retirement Income Security Act of 1974, as amended; **or**
- 22 **(P) Coverage provided by the Affordable Health Care for All Oregon Plan.**
- 23 (c) For purposes of this subsection, renewal of a short term health insurance policy includes the
- 24 issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days
- 25 after the expiration of a policy previously issued by the insurer to the policyholder.
- 26 [(21)] (17) "Health statement" means any information that is intended to inform the carrier or
- 27 insurance producer of the health status of an enrollee or prospective enrollee in a health benefit
- 28 plan. "Health statement" includes the standard health statement approved by the director under
- 29 ORS 743.745.
- 30 [(22)] (18) "Individual coverage waiting period" means a period in an individual health benefit
- 31 plan during which no premiums may be collected and health benefit plan coverage issued is not ef-
- 32 fective.
- 33 [(23)] (19) "Initial enrollment period" means a period of at least 30 days following commence-
- 34 ment of the first eligibility period for an individual.
- 35 [(24)] (20) "Late enrollee" means an individual who enrolls in a group health benefit plan sub-
- 36 sequent to the initial enrollment period during which the individual was eligible for coverage but
- 37 declined to enroll. However, an eligible individual shall not be considered a late enrollee if:
- 38 (a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg
- 39 as amended and in effect on February 17, 2009;
- 40 (b) The individual applies for coverage during an open enrollment period;
- 41 (c) A court issues an order that coverage be provided for a spouse or minor child under an
- 42 employee's employer sponsored health benefit plan and request for enrollment is made within 30
- 43 days after issuance of the court order;
- 44 (d) The individual is employed by an employer that offers multiple health benefit plans and the
- 45 individual elects a different health benefit plan during an open enrollment period; or

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

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

7 [(26)] (21) "Multiple employer welfare arrangement" means a multiple employer welfare ar-
 8 rangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974,
 9 as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

10 [(27) "*Oregon Medical Insurance Pool*" means the pool created under ORS 735.610.]

11 [(28)] (22) "Preexisting condition exclusion" means a health benefit plan provision applicable to
 12 an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during
 13 a specified period immediately following enrollment for a condition for which medical advice, diag-
 14 nosis, care or treatment was recommended or received during a specified period immediately pre-
 15 ceding enrollment. For purposes of ORS 743.730 to 743.773:

16 (a) Pregnancy does not constitute a preexisting condition except as provided in ORS 743.766;

17 (b) Genetic information does not constitute a preexisting condition in the absence of a diagnosis
 18 of the condition related to such information; and

19 (c) Except for coverage under an individual grandfathered health plan, a preexisting condition
 20 exclusion may not exclude coverage for services, charges or expenses incurred by an individual who
 21 is under 19 years of age.

22 [(29)] (23) "Premium" includes insurance premiums or other fees charged for a health benefit
 23 plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees cov-
 24 ered by the plan.

25 [(30)] (24) "Rating period" means the 12-month calendar period for which premium rates estab-
 26 lished by a carrier are in effect, as determined by the carrier.

27 [(31)] (25) "Representative" does not include an insurance producer or an employee or author-
 28 ized representative of an insurance producer or carrier.

29 [(32) "*Silver plan*" means an individual or small group health benefit plan that meets the criteria
 30 for a silver plan prescribed by the director by rule pursuant to ORS 743.822 (2).]

31 [(33)(a)] (26)(a) "Small employer" means an employer that employed an average of at least two
 32 but not more than 50 employees on business days during the preceding calendar year, the majority
 33 of whom are employed within this state, and that employs at least two eligible employees on the date
 34 on which coverage takes effect under a health benefit plan offered by the employer.

35 (b) Any person that is treated as a single employer under subsection (b), (c), (m) or (o) of section
 36 414 of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this
 37 subsection.

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

41 **SECTION 68.** ORS 743.748, as amended by section 18, chapter 500, Oregon Laws 2011, is
 42 amended to read:

43 743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the De-
 44 partment of Consumer and Business Services on or before April 1 of each year a report that con-
 45 tains:

1 (a) The following information for the preceding year that is derived from the exhibit of premi-
 2 ums, enrollment and utilization included in the carrier's annual report:

3 (A) The total number of members;

4 (B) The total amount of premiums;

5 (C) The total amount of costs for claims;

6 (D) The medical loss ratio;

7 (E) The average amount of premiums per member per month; and

8 (F) The percentage change in the average premium per member per month, measured from the
 9 previous year.

10 (b) The following aggregate financial information for the preceding year that is derived from the
 11 carrier's annual report:

12 (A) The total amount of general administrative expenses, including identification of the five
 13 largest nonmedical administrative expenses [*and the assessment against the carrier for the Oregon*
 14 *Medical Insurance Pool*];

15 (B) The total amount of the surplus maintained;

16 (C) The total amount of the reserves maintained for unpaid claims;

17 (D) The total net underwriting gain or loss; and

18 (E) The carrier's net income after taxes.

19 (2) A carrier shall electronically submit the information described in subsection (1) of this sec-
 20 tion in a format and according to instructions prescribed by the Department of Consumer and
 21 Business Services by rule.

22 (3) The department shall evaluate the reporting requirements under subsection (1)(a) of this
 23 section by the following market segments:

24 (a) Individual health benefit plans;

25 (b) Health benefit plans for small employers;

26 (c) Health benefit plans for employers described in ORS 743.733; and

27 (d) Health benefit plans for employers with more than 50 employees.

28 (4) The department shall make the information reported under this section available to the
 29 public through a searchable public website on the Internet.

30 **SECTION 69.** ORS 743.766, as amended by section 4, chapter 24, Oregon Laws 2012, is amended
 31 to read:

32 743.766. (1) All carriers that offer an individual health benefit plan and evaluate the health
 33 status of individuals for purposes of eligibility shall use the standard health statement established
 34 under ORS 743.745 and may not use any other method to determine the health status of an individ-
 35 ual. Nothing in this subsection shall prevent a carrier from using health information after enroll-
 36 ment for the purpose of providing services or arranging for the provision of services under a health
 37 benefit plan.

38 (2)(a) If an individual is accepted for coverage under an individual health benefit plan, the car-
 39 rier shall not impose exclusions or limitations other than:

40 (A) A preexisting condition exclusion that complies with the following requirements:

41 (i) The exclusion applies only to a condition for which medical advice, diagnosis, care or treat-
 42 ment was recommended or received during the six-month period immediately preceding the
 43 individual's effective date of coverage;

44 (ii) The exclusion expires no later than six months after the individual's effective date of cov-
 45 erage; and

1 (iii) Except for grandfathered health plans, the exclusion does not apply to individuals who are
 2 under 19 years of age;

3 (B) An individual coverage waiting period of 90 days; or

4 (C) An exclusion period for specified covered services applicable to all individuals enrolling for
 5 the first time in the individual health benefit plan.

6 (b) Except for grandfathered health plans, pregnancy of individuals who are under 19 years of
 7 age may not constitute a preexisting condition for purposes of this section.

8 (3) If the carrier elects to restrict coverage through the application of a preexisting condition
 9 exclusion or an individual coverage waiting period provision, the carrier shall reduce the duration
 10 of the provision by an amount equal to the individual's aggregate periods of creditable coverage if
 11 the most recent period of creditable coverage is ongoing or ended within 63 days after the effective
 12 date of coverage in the new individual health benefit plan. The crediting of prior coverage in ac-
 13 cordance with this subsection shall be applied without regard to the specific benefits covered during
 14 the prior period.

15 *[(4) If an eligible prospective enrollee is rejected for coverage under an individual health benefit*
 16 *plan, the prospective enrollee shall be eligible to apply for coverage under the Oregon Medical Insur-*
 17 *ance Pool.]*

18 *[(5)]* (4) If a carrier accepts an individual for coverage under an individual health benefit plan,
 19 the carrier shall renew the policy unless:

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

21 (b) The policyholder or a representative of the policyholder engages in fraud or makes an in-
 22 tentional misrepresentation of a material fact as prohibited by the terms of the policy.

23 (c) The carrier discontinues offering or renewing, or offering and renewing, all of its individual
 24 health benefit plans in this state or in a specified service area within this state. In order to dis-
 25 continue the plans under this paragraph, the carrier:

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

28 (B) May not cancel coverage under the plans for 180 days after the date of the notice required
 29 under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except
 30 as provided in subparagraph (C) of this paragraph, in a specified service area;

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

35 (D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans
 36 issued by the carrier in the individual market in this state or in the specified service area.

37 (d) The carrier discontinues offering and renewing an individual health benefit plan in a speci-
 38 fied service area within this state because of an inability to reach an agreement with the health
 39 care providers or organization of health care providers to provide services under the plan within the
 40 service area. In order to discontinue a plan under this paragraph, the carrier:

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

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

45 (C) Must offer in writing to each policyholder covered by the plan, all other individual health

1 benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans
2 at least 90 days prior to discontinuation.

3 (e) The carrier discontinues offering or renewing, or offering and renewing, an individual health
4 benefit plan, other than a grandfathered health plan, for all individuals in this state or in a specified
5 service area within this state, other than a plan discontinued under paragraph (d) of this subsection.

6 (f) The carrier discontinues renewing or offering and renewing a grandfathered health plan for
7 all individuals in this state or in a specified service area within this state, other than a plan dis-
8 continued under paragraph (d) of this subsection.

9 (g) With respect to plans that are being discontinued under paragraph (e) or (f) of this sub-
10 section, the carrier must:

11 (A) Offer in writing to each policyholder covered by the plan, all health benefit plans that the
12 carrier offers to individuals in the specified service area.

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

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

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

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

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

21 (i) In the case of an individual health benefit plan that delivers covered services through a
22 specified network of health care providers, the enrollee no longer lives, resides or works in the
23 service area of the provider network and the termination of coverage is not related to the health
24 status of any enrollee.

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

28 [(6)] (5) A carrier may modify an individual health benefit plan at the time of coverage renewal.
29 The modification is not a discontinuation of the plan under subsection [(5)(c)] (4)(c), (e) and (f) of
30 this section.

31 [(7)] (6) Notwithstanding any other provision of this section, and subject to the provisions of
32 ORS 743.894 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder
33 or a representative of the policyholder:

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

35 (b) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the
36 policy.

37 [(8)] (7) A carrier that withdraws from the market for individual health benefit plans must con-
38 tinue to renew its portability health benefit plans that have been approved pursuant to ORS 743.761.

39 [(9)] (8) A carrier that continues to offer coverage in the individual market in this state is not
40 required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier
41 elects to continue a plan that is closed to new individual policyholders instead of offering alterna-
42 tive coverage in its other individual health benefit plans, the coverage for all existing policyholders
43 in the closed plan is renewable in accordance with subsection [(5)] (4) of this section.

44 [(10)] (9) An individual health benefit plan may not impose annual or lifetime limits on the dollar
45 amount of the essential health benefits prescribed by the United States Secretary of Health and

1 Human Services pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law.

2 [(11)] (10) This section does not require a carrier to actively market, offer, issue or accept ap-
3 plications for a grandfathered health plan or from an individual not eligible for coverage under such
4 a plan as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by
5 the Health Care and Education Reconciliation Act (P.L. 111-152).

6 **SECTION 70.** ORS 743.767 is amended to read:

7 743.767. Premium rates for individual health benefit plans shall be subject to the following pro-
8 visions:

9 (1) Each carrier must file the carrier's initial geographic average rate and any changes to the
10 geographic average rate for its individual health benefit plans with the Director of the Department
11 of Consumer and Business Services.

12 (2) The premium rates charged during a rating period for individual health benefit plans issued
13 to individuals shall not vary from the individual geographic average rate, except that the premium
14 rate may be adjusted to reflect differences in benefit design, family composition and age. For age
15 adjustments to the individual plans, a carrier shall apply uniformly its schedule of age adjustments
16 for individual health benefit plans as approved by the director.

17 (3) A carrier may not increase the rates of an individual health benefit plan more than once in
18 a 12-month period except as approved by the director. Annual rate increases shall be effective on
19 the anniversary date of the individual health benefit plan's issuance. The percentage increase in the
20 premium rate charged for an individual health benefit plan for a new rating period may not exceed
21 the sum of the following:

22 (a) The percentage change in the carrier's geographic average rate for its individual health
23 benefit plan measured from the first day of the prior rating period to the first day of the new period;
24 and

25 (b) Any adjustment attributable to changes in age and differences in benefit design and family
26 composition.

27 (4) Notwithstanding any other provision of this section, a carrier that imposes an individual
28 coverage waiting period pursuant to ORS 743.766 may impose a monthly premium rate surcharge for
29 a period not to exceed six months and in an amount not to exceed *[the percentage by which the rates*
30 *for coverage under the Oregon Medical Insurance Pool exceed the rates established by the Oregon*
31 *Medical Insurance Pool Board as applicable for individual risks under ORS 735.625]* **a percentage**
32 **adopted by the director by rule.** The surcharge *[shall]* **must** be approved by the director *[of the*
33 *Department of Consumer and Business Services]* and, in combination with the waiting period, *[shall]*
34 **may** not exceed the actuarial value of a six-month preexisting condition exclusion.

35 **SECTION 71.** ORS 743.769 is amended to read:

36 743.769. (1) Each carrier shall actively market all individual health benefit plans sold by the
37 carrier.

38 (2) Except as provided in subsection (3) of this section, no carrier or insurance producer shall,
39 directly or indirectly, discourage an individual from filing an application for coverage because of the
40 health status, claims experience, occupation or geographic location of the individual.

41 (3) Subsection (2) of this section does not apply with respect to information provided by a carrier
42 to an individual regarding the established geographic service area or a restricted network provision
43 of a carrier.

44 (4) Rejection by a carrier of an application for coverage shall be in writing and shall state the
45 reason or reasons for the rejection.

1 (5) The Director of the Department of Consumer and Business Services may establish by rule
2 additional standards to provide for the fair marketing and broad availability of individual health
3 benefit plans.

4 (6) A carrier that elects to discontinue offering all of its individual health benefit plans under
5 ORS 743.766 [(5)(c)] (4)(c) or to discontinue offering and renewing all such plans is prohibited from
6 offering and renewing health benefit plans in the individual market in this state for a period of five
7 years from the date of notice to the director pursuant to ORS 743.766 [(5)(c)] (4)(c) or, if such notice
8 is not provided, from the date on which the director provides notice to the carrier that the director
9 has determined that the carrier has effectively discontinued offering individual health benefit plans
10 in this state. This subsection does not apply with respect to a health benefit plan discontinued in
11 a specified service area by a carrier that covers services provided only by a particular organization
12 of health care providers or only by health care providers who are under contract with the carrier.

13 **SECTION 72.** ORS 743A.001 is amended to read:

14 743A.001. (1) [*Except as provided in subsection (4) of this section,*] Any statute described in sub-
15 section (2) of this section:

16 (a) That becomes effective on or after July 13, 1985, **except as provided in subsection (4) of**
17 **this section**, is repealed on the sixth anniversary of the effective date of the statute, unless the
18 Legislative Assembly specifically provides otherwise; **and**

19 **(b) Does not apply to any insurer with respect to services covered in the Affordable**
20 **Health Care for All Oregon Plan.**

21 (2) This section governs any statute that applies to individual or group health insurance policies
22 and does any of the following:

23 (a) Requires the insurer to include coverage for specific physical or mental conditions or specific
24 hospital, medical, surgical or dental health services.

25 (b) Requires the insurer to include coverage for specified persons.

26 (c) Requires the insurer to provide payment or reimbursement to specified providers of services
27 if the services are within the lawful scope of practice of the provider and the insurance policy pro-
28 vides payment or reimbursement for those services.

29 (d) Requires the insurer to provide any specific coverage on a nondiscriminatory basis.

30 (e) Forbids the insurer to exclude from payment or reimbursement any covered services.

31 (f) Forbids the insurer to exclude coverage of a person because of that person's medical history.

32 (3) A repeal of a statute under subsection (1) of this section does not apply to any insurance
33 policy in effect on the effective date of the repeal. However, the repeal of the statute applies to a
34 renewal or extension of an existing insurance policy on or after the effective date of the repealer
35 as well as to a new policy issued on or after the effective date of the repealer.

36 (4) [*This section*] **Subsection (1)(a) of this section** does not apply to ORS 743A.020, 743A.080,
37 743A.100, 743A.104 and 743A.108.

38 **SECTION 73.** ORS 743A.012 is amended to read:

39 743A.012. (1) As used in this section:

40 (a) "Emergency medical condition" means a medical condition:

41 (A) That manifests itself by acute symptoms of sufficient severity, including severe pain, that a
42 prudent layperson possessing an average knowledge of health and medicine would reasonably expect
43 that failure to receive immediate medical attention would:

44 (i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious
45 jeopardy;

- 1 (ii) Result in serious impairment to bodily functions; or
 2 (iii) Result in serious dysfunction of any bodily organ or part; or
 3 (B) With respect to a pregnant woman who is having contractions, for which there is inadequate
 4 time to effect a safe transfer to another hospital before delivery or for which a transfer may pose
 5 a threat to the health or safety of the woman or the unborn child.
- 6 (b) “Emergency medical screening exam” means the medical history, examination, ancillary tests
 7 and medical determinations required to ascertain the nature and extent of an emergency medical
 8 condition.
- 9 (c) “Emergency services” means, with respect to an emergency medical condition:
 10 (A) An emergency medical screening exam that is within the capability of the emergency de-
 11 partment of a hospital, including ancillary services routinely available to the emergency department
 12 to evaluate such emergency medical condition; and
 13 (B) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to
 14 stabilize a patient, to the extent the examination and treatment are within the capability of the staff
 15 and facilities available at a hospital.
- 16 (d) “Grandfathered health plan” has the meaning given that term in ORS 743.730.
 17 (e) “Health benefit plan” has the meaning given that term in ORS 743.730.
 18 (f) “Prior authorization” has the meaning given that term in ORS 743.801.
 19 (g) “Stabilize” means to provide medical treatment as necessary to:
 20 (A) Ensure that, within reasonable medical probability, no material deterioration of an emer-
 21 gency medical condition is likely to occur during or to result from the transfer of the patient from
 22 a facility; and
 23 (B) With respect to a pregnant woman who is in active labor, to perform the delivery, including
 24 the delivery of the placenta.
- 25 (2) All insurers offering a health benefit plan shall provide coverage without prior authorization
 26 for emergency services.
- 27 (3) **Except as provided in section 3 of this 2013 Act**, a health benefit plan, other than a
 28 grandfathered health plan, must provide coverage required by subsection (2) of this section:
 29 (a) For the services of participating providers, without regard to any term or condition of cov-
 30 erage other than:
 31 (A) The coordination of benefits;
 32 (B) An affiliation period or waiting period permitted under part 7 of the Employee Retirement
 33 Income Security Act, part A of Title XXVII of the Public Health Service Act or chapter 100 of the
 34 Internal Revenue Code;
 35 (C) An exclusion other than an exclusion of emergency services; or
 36 (D) Applicable cost-sharing; and
 37 (b) For the services of a nonparticipating provider:
 38 (A) Without imposing any administrative requirement or limitation on coverage that is more
 39 restrictive than requirements or limitations that apply to participating providers;
 40 (B) Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate
 41 for participating providers;
 42 (C) Without imposing a deductible, unless the deductible applies generally to nonparticipating
 43 providers; and
 44 (D) Subject only to an out-of-pocket maximum that applies to all services from nonparticipating
 45 providers.

1 (4) All insurers offering a health benefit plan shall provide information to enrollees in plain
2 language regarding:

- 3 (a) What constitutes an emergency medical condition;
- 4 (b) The coverage provided for emergency services;
- 5 (c) How and where to obtain emergency services; and
- 6 (d) The appropriate use of 9-1-1.

7 (5) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and
8 may not deny coverage for emergency services solely because 9-1-1 was used.

9 (6) This section is exempt from ORS 743A.001.

10 **SECTION 74.** ORS 743A.070 is amended to read:

11 743A.070. (1) **Except as provided in section 3 of this 2013 Act**, all policies providing health
12 insurance, as defined in ORS 731.162, except those policies whose coverage is limited to expenses
13 from accidents or specific diseases that are unrelated to the coverage required by this section, shall
14 include coverage for a nonprescription elemental enteral formula for home use, if the formula is
15 medically necessary for the treatment of severe intestinal malabsorption and a physician has issued
16 a written order for the formula and the formula comprises the sole source, or an essential source,
17 of nutrition.

18 (2) The coverage required by subsection (1) of this section may be made subject to provisions
19 of the policy that apply to other benefits under the policy including, but not limited to, provisions
20 related to deductibles and coinsurance. Deductibles and coinsurance for elemental enteral formulas
21 shall be no greater than those for any other treatment for the condition under the policy.

22 (3) This section is exempt from ORS 743A.001.

23 **SECTION 75.** ORS 743A.080 is amended to read:

24 743A.080. (1) As used in this section, “pregnancy care” means the care necessary to support a
25 healthy pregnancy and care related to labor and delivery.

26 (2) **Except as provided in section 3 of this 2013 Act**, all health benefit plans as defined in
27 ORS 743.730 must provide payment or reimbursement for expenses associated with pregnancy care
28 and childbirth. Benefits provided under this section shall be extended to all enrollees, enrolled
29 spouses and enrolled dependents.

30 **SECTION 76.** ORS 743A.100 is amended to read:

31 743A.100. (1) **Except as provided in section 3 of this 2013 Act**, every health insurance policy
32 that covers hospital, medical or surgical expenses, other than coverage limited to expenses from
33 accidents or specific diseases, shall provide coverage of mammograms as follows:

- 34 (a) Mammograms for the purpose of diagnosis in symptomatic or high-risk women at any time
35 upon referral of the woman’s health care provider; and
- 36 (b) An annual mammogram for the purpose of early detection for a woman 40 years of age or
37 older, with or without referral from the woman’s health care provider.

38 (2) An insurance policy described in subsection (1) of this section must not limit coverage of
39 mammograms to the schedule provided in subsection (1) of this section if the woman is determined
40 by her health care provider to be at high risk for breast cancer.

41 **SECTION 77.** ORS 743A.104 is amended to read:

42 743A.104. **Except as provided in section 3 of this 2013 Act**, all policies providing health in-
43 surance, except those policies whose coverage is limited to expenses from accidents or specific dis-
44 eases that are unrelated to the coverage required by this section, shall include coverage for pelvic
45 examinations and Pap smear examinations as follows:

- 1 (1) Annually for women 18 to 64 years of age; and
- 2 (2) At any time upon referral of the woman's health care provider.

3 **SECTION 78.** ORS 743A.105 is amended to read:

4 743A.105. (1) **Except as provided in section 3 of this 2013 Act**, all health benefit plans, as
 5 defined in ORS 743.730, shall include coverage of the human papillomavirus vaccine for female ben-
 6 eficiaries under the health benefit plan who are at least 11 years of age but no older than 26 years
 7 of age.

- 8 (2) ORS 743A.001 does not apply to this section.

9 **SECTION 79.** ORS 743A.108 is amended to read:

10 743A.108. (1) **Except as provided in section 3 of this 2013 Act**, a health insurance policy that
 11 covers hospital, medical or surgical expenses, other than coverage limited to expenses from acci-
 12 dents or specific diseases, shall provide coverage for a complete and thorough physical examination
 13 of the breast, including but not limited to a clinical breast examination, performed by a health care
 14 provider to check for lumps and other changes for the purpose of early detection and prevention of
 15 breast cancer as follows:

- 16 (a) Annually for women 18 years of age and older; and
- 17 (b) At any time at the recommendation of the woman's health care provider.

18 (2) An insurance policy must provide coverage of physical examinations of the breast as de-
 19 scribed in subsection (1) of this section regardless of whether a health care provider performs other
 20 preventative women's health examinations or makes a referral for other preventative women's health
 21 examinations at the same time the health care provider performs the breast examination.

22 (3) This section applies to health care service contractors, as defined in ORS 750.005, and trusts
 23 carrying out a multiple employer welfare arrangement, as defined in ORS 750.301.

24 **SECTION 80.** ORS 743A.110 is amended to read:

25 743A.110. (1) As used in this section, "mastectomy" means the surgical removal of all or part
 26 of a breast or a breast tumor suspected to be malignant.

27 (2) **Except as provided in section 3 of this 2013 Act**, all insurers offering a health benefit plan
 28 as defined in ORS 743.730 shall provide payment, coverage or reimbursement for mastectomy and for
 29 the following services related to a mastectomy as determined by the attending physician and
 30 enrollee to be part of the enrollee's course or plan of treatment:

- 31 (a) All stages of reconstruction of the breast on which a mastectomy was performed, including
- 32 but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;
- 33 (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- 34 (c) Prostheses;
- 35 (d) Treatment of physical complications of the mastectomy, including lymphedemas; and
- 36 (e) Inpatient care related to the mastectomy and post-mastectomy services.

37 (3) An insurer providing coverage under subsection (2) of this section shall provide written no-
 38 tice describing the coverage to the enrollee at the time of enrollment in the health benefit plan and
 39 annually thereafter.

40 (4) A health benefit plan must provide a single determination of prior authorization for all ser-
 41 vices related to a mastectomy covered under subsection (2) of this section that are part of the
 42 enrollee's course or plan of treatment.

43 (5) When an enrollee requests an external review of an adverse benefit determination as defined
 44 in ORS 743.801 by the insurer regarding services described in subsection (2) of this section, the
 45 insurer or the Director of the Department of Consumer and Business Services must expedite the

1 enrollee's case pursuant to ORS 743.857 (5).

2 (6) The coverage required under subsection (2) of this section is subject to the same terms and
3 conditions in the plan that apply to other benefits under the plan.

4 (7) This section is exempt from ORS 743A.001.

5 **SECTION 81.** ORS 743A.120 is amended to read:

6 743A.120. (1) **Except as provided in section 3 of this 2013 Act**, an insurer offering a health
7 insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to
8 expenses from accidents or specific diseases, shall provide coverage for prostate cancer screening
9 examinations including a digital rectal examination and a prostate-specific antigen test:

10 (a) For men who are 50 years of age or older biennially or as determined by the treating phy-
11 sician; and

12 (b) For men younger than 50 years of age who are at high risk for prostate cancer as determined
13 by the treating physician, including African-American men and men with a family medical history
14 of prostate cancer.

15 (2) Health care service contractors, as defined in ORS 750.005, and trusts carrying out a multiple
16 employer welfare arrangement, as defined in ORS 750.301, are subject to subsection (1) of this sec-
17 tion.

18 **SECTION 82.** ORS 743A.124 is amended to read:

19 743A.124. (1) **Except as provided in section 3 of this 2013 Act**, an insurer offering a health
20 insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to
21 expenses from accidents or specific diseases, shall provide coverage for the following colorectal
22 cancer screening examinations and laboratory tests:

23 (a) For an insured 50 years of age or older:

24 (A) One fecal occult blood test per year plus one flexible sigmoidoscopy every five years;

25 (B) One colonoscopy every 10 years; or

26 (C) One double contrast barium enema every five years.

27 (b) For an insured who is at high risk for colorectal cancer, colorectal cancer screening exam-
28 inations and laboratory tests as recommended by the treating physician.

29 (2) For the purposes of subsection (1)(b) of this section, an individual is at high risk for
30 colorectal cancer if the individual has:

31 (a) A family medical history of colorectal cancer;

32 (b) A prior occurrence of cancer or precursor neoplastic polyps;

33 (c) A prior occurrence of a chronic digestive disease condition such as inflammatory bowel dis-
34 ease, Crohn's disease or ulcerative colitis; or

35 (d) Other predisposing factors.

36 (3) Health care service contractors, as defined in ORS 750.005, and trusts carrying out a multiple
37 employer welfare arrangement, as defined in ORS 750.301, are also subject to this section.

38 **SECTION 83.** ORS 743A.141 is amended to read:

39 743A.141. (1) As used in this section, "hearing aid" means any nondisposable, wearable instru-
40 ment or device designed to aid or compensate for impaired human hearing and any necessary ear
41 mold, part, attachments or accessory for the instrument or device, except batteries and cords.

42 (2) **Except as provided in section 3 of this 2013 Act**, a health benefit plan, as defined in ORS
43 743.730, shall provide payment, coverage or reimbursement for one hearing aid per hearing impaired
44 ear if:

45 (a) Prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed

1 physician; and

2 (b) Necessary for the treatment of hearing loss in an enrollee in the plan who is:

3 (A) 18 years of age or younger; or

4 (B) 19 to 25 years of age and enrolled in a secondary school or an accredited educational in-
5 stitution.

6 (3)(a) The maximum benefit amount required by this section is \$4,000 every 48 months, but a
7 health benefit plan may offer a benefit that is more favorable to the enrollee. The benefit amount
8 shall be adjusted on January 1 of each year to reflect the increase since January 1, 2010, in the
9 U.S. City Average Consumer Price Index for All Urban Consumers for medical care as published by
10 the Bureau of Labor Statistics of the United States Department of Labor.

11 (b) A health benefit plan may not impose any financial or contractual penalty upon an
12 audiologist if an enrollee elects to purchase a hearing aid priced higher than the benefit amount by
13 paying the difference between the benefit amount and the price of the hearing aid.

14 (4) A health benefit plan may subject the payment, coverage or reimbursement required under
15 this section to provisions of the plan that apply to other durable medical equipment benefits covered
16 by the plan, including but not limited to provisions relating to deductibles, coinsurance and prior
17 authorization.

18 (5) This section is exempt from ORS 743A.001.

19 **SECTION 84.** ORS 743A.144 is amended to read:

20 743A.144. (1) **Except as provided in section 3 of this 2013 Act**, all individual and group health
21 insurance policies providing coverage for hospital, medical or surgical expenses shall include cov-
22 erage for prosthetic and orthotic devices that are medically necessary to restore or maintain the
23 ability to complete activities of daily living or essential job-related activities and that are not solely
24 for comfort or convenience. The coverage required by this subsection includes all services and sup-
25 plies medically necessary for the effective use of a prosthetic or orthotic device, including formu-
26 lating its design, fabrication, material and component selection, measurements, fittings, static and
27 dynamic alignments, and instructing the patient in the use of the device.

28 (2) As used in this section:

29 (a) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot,
30 arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm,
31 hand, back or neck.

32 (b) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole
33 or in part an arm or a leg.

34 (3) The Director of the Department of Consumer and Business Services shall adopt and annually
35 update rules listing the prosthetic and orthotic devices covered under this section. The list shall be
36 no more restrictive than the list of prosthetic and orthotic devices and supplies in the Medicare fee
37 schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies, but only to the extent
38 consistent with this section.

39 (4) The coverage required by subsection (1) of this section may be made subject to, and no more
40 restrictive than, the provisions of a health insurance policy that apply to other benefits under the
41 policy.

42 (5) The coverage required by subsection (1) of this section shall include any repair or replace-
43 ment of a prosthetic or orthotic device that is determined medically necessary to restore or maintain
44 the ability to complete activities of daily living or essential job-related activities and that is not
45 solely for comfort or convenience.

1 (6) If coverage under subsection (1) of this section is provided through a managed care plan, the
2 insured shall have access to medically necessary clinical care and to prosthetic and orthotic devices
3 and technology from not less than two distinct Oregon prosthetic and orthotic providers in the
4 managed care plan's provider network.

5 **SECTION 85.** ORS 743A.148 is amended to read:

6 743A.148. (1) The Legislative Assembly declares that all group health insurance policies pro-
7 viding hospital, medical or surgical expense benefits include coverage for maxillofacial prosthetic
8 services considered necessary for adjunctive treatment **unless the coverage is available through**
9 **the Affordable Health Care for All Oregon Plan.**

10 (2) As used in this section, "maxillofacial prosthetic services considered necessary for adjunctive
11 treatment" means restoration and management of head and facial structures that cannot be replaced
12 with living tissue and that are defective because of disease, trauma or birth and developmental
13 deformities when such restoration and management are performed for the purpose of:

14 (a) Controlling or eliminating infection;

15 (b) Controlling or eliminating pain; or

16 (c) Restoring facial configuration or functions such as speech, swallowing or chewing but not
17 including cosmetic procedures rendered to improve on the normal range of conditions.

18 (3) The coverage required by subsection (1) of this section may be made subject to provisions
19 of the policy that apply to other benefits under the policy including, but not limited to, provisions
20 relating to deductibles and coinsurance.

21 (4) The services described in this section shall apply to individual health policies entered into
22 or renewed on or after January 1, 1982.

23 **SECTION 86.** ORS 743A.160 is amended to read:

24 743A.160. **Except as provided in section 3 of this 2013 Act,** a health insurance policy provid-
25 ing coverage for hospital or medical expenses not limited to expenses from accidents or specified
26 sicknesses shall provide, at the request of the applicant, coverage for expenses arising from treat-
27 ment for alcoholism. The following conditions apply to the requirement for such coverage:

28 (1) The applicant shall be informed of the applicant's option to request this coverage.

29 (2) The inclusion of the coverage may be made subject to the insurer's usual underwriting re-
30 quirements.

31 (3) The coverage may be made subject to provisions of the policy that apply to other benefits
32 under the policy, including but not limited to provisions relating to deductibles and coinsurance.

33 (4) The policy may limit hospital expense coverage to treatment provided by the following fa-
34 cilities:

35 (a) A health care facility licensed as required by ORS 441.015.

36 (b) A health care facility accredited by the Joint Commission on Accreditation of Hospitals.

37 (5) Except as permitted by subsection (3) of this section, the policy shall not limit payments
38 thereunder for alcoholism to an amount less than \$4,500 in any 24-consecutive month period and the
39 policy shall provide coverage, within the limits of this subsection, of not less than 80 percent of the
40 hospital and medical expenses for treatment for alcoholism.

41 **SECTION 87.** ORS 743A.168 is amended to read:

42 743A.168. **Except as provided in section 3 of this 2013 Act,** a group health insurance policy
43 providing coverage for hospital or medical expenses shall provide coverage for expenses arising from
44 treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at
45 the same level as, and subject to limitations no more restrictive than, those imposed on coverage

1 or reimbursement of expenses arising from treatment for other medical conditions. The following
 2 apply to coverage for chemical dependency and for mental or nervous conditions:

3 (1) As used in this section:

4 (a) "Chemical dependency" means the addictive relationship with any drug or alcohol charac-
 5 terized by a physical or psychological relationship, or both, that interferes on a recurring basis with
 6 the individual's social, psychological or physical adjustment to common problems. For purposes of
 7 this section, "chemical dependency" does not include addiction to, or dependency on, tobacco, to-
 8 bacco products or foods.

9 (b) "Facility" means a corporate or governmental entity or other provider of services for the
 10 treatment of chemical dependency or for the treatment of mental or nervous conditions.

11 (c) "Group health insurer" means an insurer, a health maintenance organization or a health care
 12 service contractor.

13 (d) "Program" means a particular type or level of service that is organizationally distinct within
 14 a facility.

15 (e) "Provider" means a person that has met the credentialing requirement of a group health
 16 insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is:

17 (A) A health care facility;

18 (B) A residential program or facility;

19 (C) A day or partial hospitalization program;

20 (D) An outpatient service; or

21 (E) An individual behavioral health or medical professional authorized for reimbursement under
 22 Oregon law.

23 (2) The coverage may be made subject to provisions of the policy that apply to other benefits
 24 under the policy, including but not limited to provisions relating to deductibles and coinsurance.
 25 Deductibles and coinsurance for treatment in health care facilities or residential programs or facil-
 26 ities may not be greater than those under the policy for expenses of hospitalization in the treatment
 27 of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be
 28 greater than those under the policy for expenses of outpatient treatment of other medical conditions.

29 (3) The coverage may not be made subject to treatment limitations, limits on total payments for
 30 treatment, limits on duration of treatment or financial requirements unless similar limitations or
 31 requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses
 32 may be limited to treatment that is medically necessary as determined under the policy for other
 33 medical conditions.

34 (4)(a) Nothing in this section requires coverage for:

35 (A) Educational or correctional services or sheltered living provided by a school or halfway
 36 house;

37 (B) A long-term residential mental health program that lasts longer than 45 days;

38 (C) Psychoanalysis or psychotherapy received as part of an educational or training program,
 39 regardless of diagnosis or symptoms that may be present;

40 (D) A court-ordered sex offender treatment program; or

41 (E) A screening interview or treatment program under ORS 813.021.

42 (b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpa-
 43 tient services under the terms of the insured's policy while the insured is living temporarily in a
 44 sheltered living situation.

45 (5) A provider is eligible for reimbursement under this section if:

- 1 (a) The provider is approved by the Department of Human Services;
- 2 (b) The provider is accredited for the particular level of care for which reimbursement is being
3 requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accredi-
4 tation of Rehabilitation Facilities;
- 5 (c) The patient is staying overnight at the facility and is involved in a structured program at
6 least eight hours per day, five days per week; or
- 7 (d) The provider is providing a covered benefit under the policy.
- 8 (6) Payments may not be made under this section for support groups.
- 9 (7) If specified in the policy, outpatient coverage may include follow-up in-home service or out-
10 patient services. The policy may limit coverage for in-home service to persons who are homebound
11 under the care of a physician.
- 12 (8) Nothing in this section prohibits a group health insurer from managing the provision of
13 benefits through common methods, including but not limited to selectively contracted panels, health
14 plan benefit differential designs, preadmission screening, prior authorization of services, utilization
15 review or other mechanisms designed to limit eligible expenses to those described in subsection (3)
16 of this section.
- 17 (9) The Legislative Assembly has found that health care cost containment is necessary and in-
18 tends to encourage insurance policies designed to achieve cost containment by ensuring that re-
19 imbursement is limited to appropriate utilization under criteria incorporated into such policies,
20 either directly or by reference.
- 21 (10)(a) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to phy-
22 sicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250
23 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed profes-
24 sional counselors and licensed marriage and family therapists, a group health insurer may provide
25 for review for level of treatment of admissions and continued stays for treatment in health care fa-
26 cilities, residential programs or facilities, day or partial hospitalization programs and outpatient
27 services by either group health insurer staff or personnel under contract to the group health insurer,
28 or by a utilization review contractor, who shall have the authority to certify for or deny level of
29 payment.
- 30 (b) Review shall be made according to criteria made available to providers in advance upon re-
31 quest.
- 32 (c) Review shall be performed by or under the direction of a medical or osteopathic physician
33 licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist
34 Examiners, a clinical social worker licensed by the State Board of Licensed Social Workers or a
35 professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed
36 Professional Counselors and Therapists, in accordance with standards of the National Committee for
37 Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Ser-
38 vices.
- 39 (d) Review may involve prior approval, concurrent review of the continuation of treatment,
40 post-treatment review or any combination of these. However, if prior approval is required, provision
41 shall be made to allow for payment of urgent or emergency admissions, subject to subsequent re-
42 view. If prior approval is not required, group health insurers shall permit providers, policyholders
43 or persons acting on their behalf to make advance inquiries regarding the appropriateness of a
44 particular admission to a treatment program. Group health insurers shall provide a timely response
45 to such inquiries. Noncontracting providers must cooperate with these procedures to the same ex-

1 tent as contracting providers to be eligible for reimbursement.

2 (11) Health maintenance organizations may limit the receipt of covered services by enrollees to
3 services provided by or upon referral by providers contracting with the health maintenance organ-
4 ization. Health maintenance organizations and health care service contractors may create substan-
5 tive plan benefit and reimbursement differentials at the same level as, and subject to limitations no
6 more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other
7 medical conditions and apply them to contracting and noncontracting providers.

8 (12) Nothing in this section prevents a group health insurer from contracting with providers of
9 health care services to furnish services to policyholders or certificate holders according to ORS
10 743.531 or 750.005, subject to the following conditions:

11 (a) A group health insurer is not required to contract with all eligible providers.

12 (b) An insurer or health care service contractor shall, subject to subsections (2) and (3) of this
13 section, pay benefits toward the covered charges of noncontracting providers of services for the
14 treatment of chemical dependency or mental or nervous conditions. The insured shall, subject to
15 subsections (2) and (3) of this section, have the right to use the services of a noncontracting provider
16 of services for the treatment of chemical dependency or mental or nervous conditions, whether or
17 not the services for chemical dependency or mental or nervous conditions are provided by con-
18 tracting or noncontracting providers.

19 (13) The intent of the Legislative Assembly in adopting this section is to reserve benefits for
20 different types of care to encourage cost effective care and to ensure continuing access to levels
21 of care most appropriate for the insured's condition and progress.

22 (14) The Director of the Department of Consumer and Business Services, after notice and hear-
23 ing, may adopt reasonable rules not inconsistent with this section that are considered necessary for
24 the proper administration of these provisions.

25 **SECTION 88.** ORS 743A.170 is amended to read:

26 743A.170. (1) **Except as provided in section 3 of this 2013 Act**, a health benefit plan as defined
27 in ORS 743.730 must provide payment, coverage or reimbursement of at least \$500 for a tobacco use
28 cessation program for a person enrolled in the plan who is 15 years of age or older.

29 (2) As used in this section, "tobacco use cessation program" means a program recommended by
30 a physician that follows the United States Public Health Service guidelines for tobacco use cessa-
31 tion. "Tobacco use cessation program" includes education and medical treatment components de-
32 signed to assist a person in ceasing the use of tobacco products.

33 (3) This section is exempt from ORS 743A.001.

34 **SECTION 89.** ORS 743A.175 is amended to read:

35 743A.175. (1) **Except as provided in section 3 of this 2013 Act**, a health benefit plan, as de-
36 fined in ORS 743.730, shall provide coverage of medically necessary therapy and services for the
37 treatment of traumatic brain injury.

38 (2) This section is exempt from ORS 743A.001.

39 **SECTION 90.** ORS 743A.184 is amended to read:

40 743A.184. (1) **Except as provided in section 3 of this 2013 Act, and** subject to other terms,
41 conditions and benefits in the plan, group health benefit plans as described in ORS 743.730 shall
42 provide payment, coverage or reimbursement for supplies, equipment and diabetes self-management
43 programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes,
44 gestational diabetes and noninsulin-using diabetes prescribed by a health care professional legally
45 authorized to prescribe such items.

1 (2) As used in this section, “diabetes self-management program” means one program of assess-
2 ment and training after diagnosis and no more than three hours per year of assessment and training
3 upon a material change of condition, medication or treatment that is provided by:

4 (a) An education program credentialed or accredited by a state or national entity accrediting
5 such programs; or

6 (b) A program provided by a physician licensed under ORS chapter 677, a registered nurse, a
7 nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise
8 in diabetes.

9 **SECTION 91.** ORS 743A.188 is amended to read:

10 743A.188. (1) **Except as provided in section 3 of this 2013 Act**, all individual and group health
11 insurance policies providing coverage for hospital, medical or surgical expenses, other than coverage
12 limited to expenses from accidents or specific diseases, shall include coverage for treatment of in-
13 born errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which
14 medically standard methods of diagnosis, treatment and monitoring exist, including quantification
15 of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage
16 shall include expenses of diagnosing, monitoring and controlling the disorders by nutritional and
17 medical assessment, including but not limited to clinical visits, biochemical analysis and medical
18 foods used in the treatment of such disorders.

19 (2) As used in this section, “medical foods” means foods that are formulated to be consumed or
20 administered enterally under the supervision of a physician, as defined in ORS 677.010, that are
21 specifically processed or formulated to be deficient in one or more of the nutrients present in typical
22 nutritional counterparts, that are for the medical and nutritional management of patients with lim-
23 ited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other
24 specific nutrient requirements as established by medical evaluation and that are essential to opti-
25 mize growth, health and metabolic homeostasis.

26 (3) This section is exempt from ORS 743A.001.

27 **SECTION 92.** ORS 743A.190 is amended to read:

28 743A.190. (1) **Except as provided in section 3 of this 2013 Act**, a health benefit plan, as de-
29 fined in ORS 743.730, must cover for a child enrolled in the plan who is under 18 years of age and
30 who has been diagnosed with a pervasive developmental disorder all medical services, including re-
31 habilitation services, that are medically necessary and are otherwise covered under the plan.

32 (2) The coverage required under subsection (1) of this section, including rehabilitation services,
33 may be made subject to other provisions of the health benefit plan that apply to covered services,
34 including but not limited to:

35 (a) Deductibles, copayments or coinsurance;

36 (b) Prior authorization or utilization review requirements; or

37 (c) Treatment limitations regarding the number of visits or the duration of treatment.

38 (3) As used in this section:

39 (a) “Medically necessary” means in accordance with the definition of medical necessity that is
40 specified in the policy, certificate or contract for the health benefit plan and that applies uniformly
41 to all covered services under the health benefit plan.

42 (b) “Pervasive developmental disorder” means a neurological condition that includes Asperger’s
43 syndrome, autism, developmental delay, developmental disability or mental retardation.

44 (c) “Rehabilitation services” means physical therapy, occupational therapy or speech therapy
45 services to restore or improve function.

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

2 (5) The definition of “pervasive developmental disorder” is not intended to apply to coverage
3 required under ORS 743A.168.

4 **SECTION 93.** ORS 743A.192 is amended to read:

5 743A.192. (1) **Except as provided in section 3 of this 2013 Act**, a health benefit plan, as de-
6 fined in ORS 743.730, shall provide coverage for the routine costs of the care of patients enrolled
7 in and participating in qualifying clinical trials.

8 (2) As used in subsection (1) of this section, “routine costs”:

9 (a) Means medically necessary conventional care, items or services covered by the health benefit
10 plan if typically provided absent a clinical trial.

11 (b) Does not include:

12 (A) The drug, device or service being tested in the clinical trial unless the drug, device or ser-
13 vice would be covered for that indication by the health benefit plan if provided outside of a clinical
14 trial;

15 (B) Items or services required solely for the provision of the drug device or service being tested
16 in the clinical trial;

17 (C) Items or services required solely for the clinically appropriate monitoring of the drug, device
18 or service being tested in the clinical trial;

19 (D) Items or services required solely for the prevention, diagnosis or treatment of complications
20 arising from the provision of the drug, device or service being tested in the clinical trial;

21 (E) Items or services that are provided solely to satisfy data collection and analysis needs and
22 that are not used in the direct clinical management of the patient;

23 (F) Items or services customarily provided by a clinical trial sponsor free of charge to any par-
24 ticipant in the clinical trial; or

25 (G) Items or services that are not covered by the health plan if provided outside of the clinical
26 trial.

27 (3) As used in subsection (1) of this section, “qualifying clinical trial” means a clinical trial that
28 is:

29 (a) Funded by the National Institutes of Health, the Centers for Disease Control and Prevention,
30 the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services,
31 the United States Department of Defense or the United States Department of Veterans Affairs;

32 (b) Supported by a center or cooperative group that is funded by the National Institutes of
33 Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and
34 Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense
35 or the United States Department of Veterans Affairs;

36 (c) Conducted as an investigational new drug application, an investigational device exemption
37 or a biologics license application subject to approval by the United States Food and Drug Adminis-
38 tration; or

39 (d) Exempt by federal law from the requirement to submit an investigational new drug applica-
40 tion to the United States Food and Drug Administration.

41 (4) The coverage required by this section may be subject to provisions of the health benefit plan
42 that apply to other benefits within the same category, including but not limited to copayments,
43 deductibles and coinsurance.

44 (5) An insurer that provides coverage required by this section is not, based upon that coverage,
45 liable for any adverse effects of the clinical trial.

1 **SECTION 94.** ORS 744.704 is amended to read:

2 744.704. (1) The following persons are exempt from the licensing requirement for third party
3 administrators in ORS 744.702 and from all other provisions of ORS 744.700 to 744.740 applicable to
4 third party administrators:

5 (a) A person licensed under ORS 744.002 as an adjuster, whose activities are limited to adjust-
6 ment of claims and whose activities do not include the activities of a third party administrator.

7 (b) A person licensed as an insurance producer as required by ORS 744.053 and authorized to
8 transact life or health insurance in this state, whose activities are limited exclusively to the sale
9 of insurance and whose activities do not include the activities of a third party administrator.

10 (c) An employer acting as a third party administrator on behalf of:

11 (A) Its employees;

12 (B) The employees of one or more subsidiary or affiliated corporations of the employer; or

13 (C) The employees of one or more persons with a dealership, franchise, distributorship or other
14 similar arrangement with the employers.

15 (d) A union, or an affiliate thereof, acting as a third party administrator on behalf of its mem-
16 bers.

17 (e) An insurer that is authorized to transact insurance in this state with respect to a policy is-
18 sued and delivered in and pursuant to the laws of this state or another state.

19 (f) A creditor acting on behalf of its debtors with respect to insurance covering a debt between
20 the creditor and its debtors.

21 (g) A trust and the trustees, agents and employees of the trust, when acting pursuant to the
22 trust, if the trust is established in conformity with 29 U.S.C. 186.

23 (h) A trust exempt from taxation under section 501(a) of the Internal Revenue Code, its trustees
24 and employees acting pursuant to the trust, or a voluntary employees beneficiary association de-
25 scribed in section 501(c) of the Internal Revenue Code, its agents and employees and a custodian
26 and the custodian's agents and employees acting pursuant to a custodian account meeting the re-
27 quirements of section 401(f) of the Internal Revenue Code.

28 (i) A financial institution that is subject to supervision or examination by federal or state fi-
29 nancial institution regulatory authorities, or a mortgage lender, to the extent the financial institu-
30 tion or mortgage lender collects and remits premiums to licensed insurance producers or authorized
31 insurers in connection with loan payments.

32 (j) A company that issues credit cards and advances for and collects premiums or charges from
33 its credit card holders who have authorized collection. The exemption under this paragraph applies
34 only if the company does not adjust or settle claims.

35 (k) A person who adjusts or settles claims in the normal course of practice or employment as
36 an attorney at law. The exemption under this subsection applies only if the person does not collect
37 charges or premiums in connection with life insurance or health insurance coverage.

38 (L) A person who acts solely as an administrator of one or more bona fide employee benefit
39 plans established by an employer or an employee organization, or both, for which the Insurance
40 Code is preempted pursuant to the Employee Retirement Income Security Act of 1974. A person to
41 whom this paragraph applies must comply with the requirements of ORS 744.714.

42 [(m) *The Oregon Medical Insurance Pool Board, established under ORS 735.600 to 735.650, and*
43 *the administering insurer or insurers for the board, for services provided pursuant to ORS 735.600 to*
44 *735.650.*]

45 [(n)] (m) An entity or association owned by or composed of like employers who administer par-

1 tially or fully self-insured plans for employees of the employers or association members.

2 [(o)] (n) A trust established by a cooperative body formed between cities, counties, districts or
 3 other political subdivisions of this state, or between any combination of such entities, and the trust-
 4 tees, agents and employees acting pursuant to the trust.

5 [(p)] (o) Any person designated by the Director of the Department of Consumer and Business
 6 Services by rule.

7 (2) A third party administrator is not required to be licensed as a third party administrator in
 8 this state if the following conditions are met:

9 (a) The third party administrator has its principal place of business in another state;

10 (b) The third party administrator is not soliciting business as a third party administrator in this
 11 state; and

12 (c) In the case of any group policy or plan of insurance serviced by the third party administra-
 13 tor, the lesser of five percent or 100 certificate holders reside in this state.

14 **SECTION 95.** ORS 746.600 is amended to read:

15 746.600. As used in ORS 746.600 to 746.690:

16 (1)(a) "Adverse underwriting decision" means any of the following actions with respect to in-
 17 surance transactions involving insurance coverage that is individually underwritten:

18 (A) A declination of insurance coverage.

19 (B) A termination of insurance coverage.

20 (C) Failure of an insurance producer to apply for insurance coverage with a specific insurer that
 21 the insurance producer represents and that is requested by an applicant.

22 (D) In the case of life or health insurance coverage, an offer to insure at higher than standard
 23 rates.

24 (E) In the case of insurance coverage other than life or health insurance coverage:

25 (i) Placement by an insurer or insurance producer of a risk with a residual market mechanism,
 26 an unauthorized insurer or an insurer that specializes in substandard risks.

27 (ii) The charging of a higher rate on the basis of information that differs from that which the
 28 applicant or policyholder furnished.

29 (iii) An increase in any charge imposed by the insurer for any personal insurance in connection
 30 with the underwriting of insurance. For purposes of this sub-subparagraph, the imposition of a ser-
 31 vice fee is not a charge.

32 (b) "Adverse underwriting decision" does not mean any of the following actions, but the insurer
 33 or insurance producer responsible for the occurrence of the action must nevertheless provide the
 34 applicant or policyholder with the specific reason or reasons for the occurrence:

35 (A) The termination of an individual policy form on a class or statewide basis.

36 (B) A declination of insurance coverage solely because the coverage is not available on a class
 37 or statewide basis.

38 (C) The rescission of a policy.

39 (2) "Affiliate of" a specified person or "person affiliated with" a specified person means a person
 40 who directly, or indirectly, through one or more intermediaries, controls, or is controlled by, or is
 41 under common control with, the person specified.

42 (3) "Applicant" means a person who seeks to contract for insurance coverage, other than a
 43 person seeking group insurance coverage that is not individually underwritten.

44 (4) "Consumer" means an individual, or the personal representative of the individual, who seeks
 45 to obtain, obtains or has obtained one or more insurance products or services from a licensee that

1 are to be used primarily for personal, family or household purposes, and about whom the licensee
2 has personal information.

3 (5) "Consumer report" means any written, oral or other communication of information bearing
4 on a natural person's creditworthiness, credit standing, credit capacity, character, general reputa-
5 tion, personal characteristics or mode of living that is used or expected to be used in connection
6 with an insurance transaction.

7 (6) "Consumer reporting agency" means a person that, for monetary fees or dues, or on a co-
8 operative or nonprofit basis:

9 (a) Regularly engages, in whole or in part, in assembling or preparing consumer reports;

10 (b) Obtains information primarily from sources other than insurers; and

11 (c) Furnishes consumer reports to other persons.

12 (7) "Control" means, and the terms "controlled by" or "under common control with" refer to,
13 the possession, directly or indirectly, of the power to direct or cause the direction of the manage-
14 ment and policies of a person, whether through the ownership of voting securities, by contract other
15 than a commercial contract for goods or nonmanagement services, or otherwise, unless the power
16 of the person is the result of a corporate office held in, or an official position held with, the con-
17 trolled person.

18 (8) "Covered entity" means:

19 (a) A health insurer;

20 (b) A health care provider that transmits any health information in electronic form to carry out
21 financial or administrative activities in connection with a transaction covered by ORS 746.607 or
22 by rules adopted under ORS 746.608; or

23 (c) A health care clearinghouse.

24 (9) "Credit history" means any written or other communication of any information by a con-
25 sumer reporting agency that:

26 (a) Bears on a consumer's creditworthiness, credit standing or credit capacity; and

27 (b) Is used or expected to be used, or collected in whole or in part, as a factor in determining
28 eligibility, premiums or rates for personal insurance.

29 (10) "Customer" means a consumer who has a continuing relationship with a licensee under
30 which the licensee provides one or more insurance products or services to the consumer that are
31 to be used primarily for personal, family or household purposes.

32 (11) "Declination of insurance coverage" or "decline coverage" means a denial, in whole or in
33 part, by an insurer or insurance producer of an application for requested insurance coverage.

34 (12) "Health care" means care, services or supplies related to the health of an individual.

35 (13) "Health care operations" includes but is not limited to:

36 (a) Quality assessment, accreditation, auditing and improvement activities;

37 (b) Case management and care coordination;

38 (c) Reviewing the competence, qualifications or performance of health care providers or health
39 insurers;

40 (d) Underwriting activities;

41 (e) Arranging for legal services;

42 (f) Business planning;

43 (g) Customer services;

44 (h) Resolving internal grievances;

45 (i) Creating deidentified information; and

- 1 (j) Fundraising.
- 2 (14) "Health care provider" includes but is not limited to:
- 3 (a) A psychologist, occupational therapist, regulated social worker, professional counselor or
 4 marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675
 5 or an employee of the psychologist, occupational therapist, regulated social worker, professional
 6 counselor or marriage and family therapist;
- 7 (b) A physician, podiatric physician and surgeon, physician assistant or acupuncturist licensed
 8 under ORS chapter 677 or an employee of the physician, podiatric physician and surgeon, physician
 9 assistant or acupuncturist;
- 10 (c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of
 11 the nurse or nursing home administrator;
- 12 (d) A dentist licensed under ORS chapter 679 or an employee of the dentist;
- 13 (e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental
 14 hygienist or denturist;
- 15 (f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee
 16 of the speech-language pathologist or audiologist;
- 17 (g) An emergency medical services provider licensed under ORS chapter 682;
- 18 (h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;
- 19 (i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic
 20 physician;
- 21 (j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic
 22 physician;
- 23 (k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage
 24 therapist;
- 25 (L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct
 26 entry midwife;
- 27 (m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical
 28 therapist;
- 29 (n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical
 30 imaging licensee;
- 31 (o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory
 32 care practitioner;
- 33 (p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the poly-
 34 somnographic technologist;
- 35 (q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;
- 36 (r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;
- 37 (s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral
 38 service practitioner;
- 39 (t) A health care facility as defined in ORS 442.015;
- 40 (u) A home health agency as defined in ORS 443.005;
- 41 (v) A hospice program as defined in ORS 443.850;
- 42 (w) A clinical laboratory as defined in ORS 438.010;
- 43 (x) A pharmacy as defined in ORS 689.005;
- 44 (y) A diabetes self-management program as defined in ORS 743.694; and
- 45 (z) Any other person or entity that furnishes, bills for or is paid for health care in the normal

1 course of business.

2 (15) "Health information" means any oral or written information in any form or medium that:

3 (a) Is created or received by a covered entity, a public health authority, a life insurer, a school,
4 a university or a health care provider that is not a covered entity; and

5 (b) Relates to:

6 (A) The past, present or future physical or mental health or condition of an individual;

7 (B) The provision of health care to an individual; or

8 (C) The past, present or future payment for the provision of health care to an individual.

9 (16) "Health insurer" means[:]

10 [(a)] an insurer who offers:

11 [(A)] (a) A health benefit plan as defined in ORS 743.730;

12 [(B)] (b) A short term health insurance policy, the duration of which does not exceed six months
13 including renewals;

14 [(C)] (c) A student health insurance policy;

15 [(D)] (d) A Medicare supplemental policy; or

16 [(E)] (e) A dental only policy.

17 [(b) *The Oregon Medical Insurance Pool operated by the Oregon Medical Insurance Pool Board*
18 *under ORS 735.600 to 735.650.*]

19 (17) "Homeowner insurance" means insurance for residential property consisting of a combina-
20 tion of property insurance and casualty insurance that provides coverage for the risks of owning
21 or occupying a dwelling and that is not intended to cover an owner's interest in rental property or
22 commercial exposures.

23 (18) "Individual" means a natural person who:

24 (a) In the case of life or health insurance, is a past, present or proposed principal insured or
25 certificate holder;

26 (b) In the case of other kinds of insurance, is a past, present or proposed named insured or
27 certificate holder;

28 (c) Is a past, present or proposed policyowner;

29 (d) Is a past or present applicant;

30 (e) Is a past or present claimant; or

31 (f) Derived, derives or is proposed to derive insurance coverage under an insurance policy or
32 certificate that is subject to ORS 746.600 to 746.690.

33 (19) "Individually identifiable health information" means any oral or written health information
34 that is:

35 (a) Created or received by a covered entity or a health care provider that is not a covered en-
36 tity; and

37 (b) Identifiable to an individual, including demographic information that identifies the individual,
38 or for which there is a reasonable basis to believe the information can be used to identify an indi-
39 vidual, and that relates to:

40 (A) The past, present or future physical or mental health or condition of an individual;

41 (B) The provision of health care to an individual; or

42 (C) The past, present or future payment for the provision of health care to an individual.

43 (20) "Institutional source" means a person or governmental entity that provides information
44 about an individual to an insurer, insurance producer or insurance-support organization, other than:

45 (a) An insurance producer;

1 (b) The individual who is the subject of the information; or

2 (c) A natural person acting in a personal capacity rather than in a business or professional ca-
3 pacity.

4 (21) "Insurance producer" or "producer" means a person licensed by the Director of the De-
5 partment of Consumer and Business Services as a resident or nonresident insurance producer.

6 (22) "Insurance score" means a number or rating that is derived from an algorithm, computer
7 application, model or other process that is based in whole or in part on credit history.

8 (23)(a) "Insurance-support organization" means a person who regularly engages, in whole or in
9 part, in assembling or collecting information about natural persons for the primary purpose of pro-
10 viding the information to an insurer or insurance producer for insurance transactions, including:

11 (A) The furnishing of consumer reports to an insurer or insurance producer for use in con-
12 nection with insurance transactions; and

13 (B) The collection of personal information from insurers, insurance producers or other
14 insurance-support organizations for the purpose of detecting or preventing fraud, material misrep-
15 resentation or material nondisclosure in connection with insurance underwriting or insurance claim
16 activity.

17 (b) "Insurance-support organization" does not mean insurers, insurance producers, governmental
18 institutions or health care providers.

19 (24) "Insurance transaction" means any transaction that involves insurance primarily for per-
20 sonal, family or household needs rather than business or professional needs and that entails:

21 (a) The determination of an individual's eligibility for an insurance coverage, benefit or payment;
22 or

23 (b) The servicing of an insurance application, policy or certificate.

24 (25) "Insurer" has the meaning given that term in ORS 731.106.

25 (26) "Investigative consumer report" means a consumer report, or portion of a consumer report,
26 for which information about a natural person's character, general reputation, personal character-
27 istics or mode of living is obtained through personal interviews with the person's neighbors, friends,
28 associates, acquaintances or others who may have knowledge concerning such items of information.

29 (27) "Licensee" means an insurer, insurance producer or other person authorized or required to
30 be authorized, or licensed or required to be licensed, pursuant to the Insurance Code.

31 (28) "Loss history report" means a report provided by, or a database maintained by, an
32 insurance-support organization or consumer reporting agency that contains information regarding
33 the claims history of the individual property that is the subject of the application for a homeowner
34 insurance policy or the consumer applying for a homeowner insurance policy.

35 (29) "Nonaffiliated third party" means any person except:

36 (a) An affiliate of a licensee;

37 (b) A person that is employed jointly by a licensee and by a person that is not an affiliate of the
38 licensee; and

39 (c) As designated by the director by rule.

40 (30) "Payment" includes but is not limited to:

41 (a) Efforts to obtain premiums or reimbursement;

42 (b) Determining eligibility or coverage;

43 (c) Billing activities;

44 (d) Claims management;

45 (e) Reviewing health care to determine medical necessity;

- 1 (f) Utilization review; and
2 (g) Disclosures to consumer reporting agencies.
- 3 (31)(a) "Personal financial information" means:
4 (A) Information that is identifiable with an individual, gathered in connection with an insurance
5 transaction from which judgments can be made about the individual's character, habits, avocations,
6 finances, occupations, general reputation, credit or any other personal characteristics; or
7 (B) An individual's name, address and policy number or similar form of access code for the
8 individual's policy.
- 9 (b) "Personal financial information" does not mean information that a licensee has a reasonable
10 basis to believe is lawfully made available to the general public from federal, state or local gov-
11 ernment records, widely distributed media or disclosures to the public that are required by federal,
12 state or local law.
- 13 (32) "Personal information" means:
14 (a) Personal financial information;
15 (b) Individually identifiable health information; or
16 (c) Protected health information.
- 17 (33) "Personal insurance" means the following types of insurance products or services that are
18 to be used primarily for personal, family or household purposes:
19 (a) Private passenger automobile coverage;
20 (b) Homeowner, mobile homeowners, manufactured homeowners, condominium owners and
21 renters coverage;
22 (c) Personal dwelling property coverage;
23 (d) Personal liability and theft coverage, including excess personal liability and theft coverage;
24 and
25 (e) Personal inland marine coverage.
- 26 (34) "Personal representative" includes but is not limited to:
27 (a) A person appointed as a guardian under ORS 125.305, 419B.370, 419C.481 or 419C.555 with
28 authority to make medical and health care decisions;
29 (b) A person appointed as a health care representative under ORS 127.505 to 127.660 or 127.700
30 to 127.737 to make health care decisions or mental health treatment decisions;
31 (c) A person appointed as a personal representative under ORS chapter 113; and
32 (d) A person described in ORS 746.611.
- 33 (35) "Policyholder" means a person who:
34 (a) In the case of individual policies of life or health insurance, is a current policyowner;
35 (b) In the case of individual policies of other kinds of insurance, is currently a named insured;
36 or
37 (c) In the case of group policies of insurance under which coverage is individually underwritten,
38 is a current certificate holder.
- 39 (36) "Pretext interview" means an interview wherein the interviewer, in an attempt to obtain
40 personal information about a natural person, does one or more of the following:
41 (a) Pretends to be someone the interviewer is not.
42 (b) Pretends to represent a person the interviewer is not in fact representing.
43 (c) Misrepresents the true purpose of the interview.
44 (d) Refuses upon request to identify the interviewer.
- 45 (37) "Privileged information" means information that is identifiable with an individual and that:

1 (a) Relates to a claim for insurance benefits or a civil or criminal proceeding involving the in-
 2 dividual; and

3 (b) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits
 4 or a civil or criminal proceeding involving the individual.

5 (38)(a) "Protected health information" means individually identifiable health information that is
 6 transmitted or maintained in any form of electronic or other medium by a covered entity.

7 (b) "Protected health information" does not mean individually identifiable health information in:

8 (A) Education records covered by the federal Family Educational Rights and Privacy Act (20
 9 U.S.C. 1232g);

10 (B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

11 (C) Employment records held by a covered entity in its role as employer.

12 (39) "Residual market mechanism" means an association, organization or other entity involved
 13 in the insuring of risks under ORS 735.005 to 735.145, 737.312 or other provisions of the Insurance
 14 Code relating to insurance applicants who are unable to procure insurance through normal insur-
 15 ance markets.

16 (40) "Termination of insurance coverage" or "termination of an insurance policy" means either
 17 a cancellation or a nonrenewal of an insurance policy, in whole or in part, for any reason other than
 18 the failure of a premium to be paid as required by the policy.

19 (41) "Treatment" includes but is not limited to:

20 (a) The provision, coordination or management of health care; and

21 (b) Consultations and referrals between health care providers.

22 **SECTION 96.** ORS 748.603 is amended to read:

23 748.603. (1) Societies are governed by this chapter and are exempt from all other provisions of
 24 the insurance laws of this state unless expressly designated therein, or unless specifically made ap-
 25 plicable by this chapter.

26 (2) ORS 705.137, 705.139, 731.004 to 731.026, 731.036 to 731.136, 731.146 to 731.156, 731.162,
 27 731.166, 731.170, 731.216 to 731.268, 731.296, 731.324, 731.328, 731.354, 731.356, 731.358, 731.378,
 28 731.380, 731.381, 731.382, 731.385, 731.386, 731.390, 731.394, 731.396, 731.398, 731.402, 731.406, 731.410,
 29 731.422 to 731.434, 731.446 to 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512,
 30 731.592, 731.594, 731.730, 731.731, 731.735, 731.737, 731.750, 731.804, 731.844 to 731.992, 731.870,
 31 732.245, 732.250, 732.320, 732.325, 733.010 to 733.050, 733.080, 733.140 to 733.210, 733.220, 733.510,
 32 733.652 to 733.658, 733.730 to 733.750, [735.600 to 735.650,] 742.001, 742.003, 742.005, 742.007, 742.009,
 33 742.013 to 742.021, 742.028, 742.038, 742.041, 742.046, 742.051, 742.150 to 742.162 and 744.700 to
 34 744.740 and ORS chapters 734, 743 and 743A apply to fraternal benefit societies to the extent not
 35 inconsistent with the express provisions of this chapter.

36 (3) For the purposes of this subsection and subsection (2) of this section, fraternal benefit soci-
 37 eties shall be deemed insurers, and benefit certificates issued by fraternal benefit societies shall be
 38 deemed policies.

39 (4) Every society authorized to do business in this state shall be subject to the provisions of
 40 ORS chapter 746 relating to unfair trade practices. However, nothing in ORS chapter 746 shall be
 41 construed as applying to or affecting the right of any society to determine its eligibility require-
 42 ments for membership, or be construed as applying to or affecting the offering of benefits exclusively
 43 to members or persons eligible for membership in the society by a subsidiary corporation or affil-
 44 iated organization of the society.

45 **SECTION 97.** ORS 750.055, as amended by section 3, chapter 21, Oregon Laws 2012, is amended

1 to read:

2 750.055. (1) The following provisions of the Insurance Code apply to health care service con-
3 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

4 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,
5 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,
6 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,
7 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

8 (b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not
9 including ORS 732.582.

10 (c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
11 to 733.780.

12 (d) ORS chapter 734.

13 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to
14 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,
15 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to
16 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to
17 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863,
18 743.864, 743.894, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036,
19 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084,
20 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148,
21 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190 and
22 743A.192 and section 2, chapter 21, Oregon Laws 2012.

23 (f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

24 (g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
25 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

26 (h) ORS 743A.024, except in the case of group practice health maintenance organizations that
27 are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is
28 referred by a physician associated with a group practice health maintenance organization.

29 [(i) ORS 735.600 to 735.650.]

30 [(j)] (i) ORS 743.680 to 743.689.

31 [(k)] (j) ORS 744.700 to 744.740.

32 [(L)] (k) ORS 743.730 to 743.773.

33 [(m)] (L) ORS 731.485, except in the case of a group practice health maintenance organization
34 that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly
35 owns and operates an in-house drug outlet.

36 (2) For the purposes of this section, health care service contractors shall be deemed insurers.

37 (3) Any for-profit health care service contractor organized under the laws of any other state that
38 is not governed by the insurance laws of the other state is subject to all requirements of ORS
39 chapter 732.

40 (4) The Director of the Department of Consumer and Business Services may, after notice and
41 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
42 and 750.045 that are deemed necessary for the proper administration of these provisions.

43 **SECTION 98.** Section 1, chapter 101, Oregon Laws 2012, is amended to read:

44 **Sec. 1.** (1) Notwithstanding ORS 291.229, a state agency that employs more than 100 employees
45 and has not, by [the effective date of this 2012 Act] **April 11, 2012**, attained a ratio of at least 11 to

1 1 of employees of the state agency who are not supervisory employees to supervisory employees:

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

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

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

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

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

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

21 (4) Upon application from a state agency, the Oregon Department of Administrative Services
 22 may grant a state agency an exception from the requirements of subsections (1) to (3) of this section
 23 if the department determines that the exception is warranted due to unique or emergency circum-
 24 stances. The department shall report all exceptions granted under this subsection to the Joint
 25 Committee on Ways and Means, the Joint Interim Committee on Ways and Means or the Emergency
 26 Board.

27 (5) As used in this section:

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

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

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

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

35 (iii) The Public Defense Services Commission;

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

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

39 (vi) The Oregon Tourism Commission;

40 (vii) The Oregon Film and Video Office;

41 (viii) The Oregon University System;

42 (ix) The Oregon Health and Science University;

43 (x) The Travel Information Council;

44 (xi) Oregon Corrections Enterprises;

45 (xii) The Oregon State Lottery Commission;

- 1 (xiii) The State Accident Insurance Fund Corporation;
- 2 [(xiv) *The Oregon Health Insurance Exchange Corporation*];
- 3 [(xv)] (xiv) The Oregon Utility Notification Center;
- 4 [(xvi)] (xv) Oregon Community Power;
- 5 [(xvii)] (xvi) The Citizens' Utility Board;
- 6 [(xviii)] (xvii) A special government body as defined in ORS 174.117;
- 7 [(xix)] (xviii) Any other public corporation created under a statute of this state and specifically
- 8 designated as a public corporation; and
- 9 [(xx)] (xix) Any other semi-independent state agency denominated by statute as a semi-
- 10 independent state agency.
- 11 (b) "Supervisory employee" has the meaning given that term in ORS 243.650.

12
13 **APPROPRIATION**

14
15 **SECTION 99. There is appropriated to the Oregon Health Authority for deposit in the**
16 **Affordable Health Care for All Oregon Fund established by section 24 of this 2013 Act, for the**
17 **biennium beginning July 1, 2013, out of the General Fund, the amount of \$_____ for the**
18 **purposes of the Affordable Health Care for All Oregon Board and administering the Afford-**
19 **able Health Care for All Oregon Plan.**

20
21 **REPEALS**

22
23 **SECTION 100. (1) ORS 414.825, 414.826, 414.828, 414.831, 414.839, 414.841, 414.842, 414.844,**
24 **414.846, 414.848, 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866,**
25 **414.868, 414.870, 414.872, 735.600, 735.605, 735.610, 735.612, 735.614, 735.615, 735.616, 735.620,**
26 **735.625, 735.630, 735.635, 735.640, 735.645, 735.650, 735.700, 735.701, 735.702, 735.703, 735.705,**
27 **735.707, 735.709, 735.710, 735.712, 741.001, 741.002, 741.025, 741.027, 741.029, 741.031, 741.101,**
28 **741.105, 741.201, 741.220, 741.222, 741.250, 741.255, 741.300, 741.310, 741.340, 741.381, 741.390,**
29 **741.500, 741.510, 741.520, 741.540, 741.900, 743.822, 743.826 and 746.222 and sections 1, 3, 4 and**
30 **5, chapter 47, Oregon Laws 2010, are repealed.**

31 **(2) Section 2, chapter 47, Oregon Laws 2010, as amended by section 22, chapter 70, Oregon**
32 **Laws 2011, is repealed.**

33
34 **CAPTIONS**

35
36 **SECTION 101. The unit captions used in this 2013 Act are provided only for the conven-**
37 **ience of the reader and do not become part of the statutory law of this state or express any**
38 **legislative intent in the enactment of this 2013 Act.**

39
40 **OPERATIVE DATES AND EMERGENCY CLAUSE**

41
42 **SECTION 102. (1) Sections 5 to 9 and 27 to 46 of this 2013 Act and the amendments to**
43 **ORS 413.032, 430.315, 442.015, 442.315 and 442.325 by sections 11 to 13, 54 and 61 of this 2013**
44 **Act become operative January 1, 2016.**

45 **(2) Sections 1 to 4 of this 2013 Act, the amendments to ORS 65.957, 192.556, 243.105,**

1 243.125, 243.135, 243.160, 243.275, 243.215, 243.860, 243.864, 243.866, 243.868, 243.886, 291.055,
 2 411.402, 413.011, 413.017, 413.032, 413.037, 413.201, 414.041, 414.231, 433.443, 705.145, 731.036,
 3 734.790, 743.402, 743.730, 743.748, 743.766, 743.767, 743.769, 743A.001, 743A.012, 743A.070,
 4 743A.080, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110, 743A.120, 743A.124, 743A.141,
 5 743A.144, 743A.148, 743A.160, 743A.168, 743A.170, 743A.175, 743A.184, 743A.188, 743A.190,
 6 743A.192,744.704, 746.600, 748.603 and 750.055 and section 1, chapter 867, Oregon Laws 2009,
 7 by sections 14 to 23, 47 to 53, 55 to 60 and 62 to 98 of this 2013 Act and the repeal of ORS
 8 414.825, 414.826, 414.828, 414.831, 414.839, 414.841, 414.842, 414.844, 414.846, 414.848, 414.851,
 9 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866, 414.868, 414.870, 414.872,
 10 735.600, 735.605, 735.610, 735.612, 735.614, 735.615, 735.616, 735.620, 735.625, 735.630, 735.635,
 11 735.640, 735.645, 735.650, 735.700, 735.701, 735.702, 735.703, 735.705, 735.707, 735.709, 735.710,
 12 735.712, 741.001, 741.002, 741.025, 741.027, 741.029, 741.031, 741.101, 741.105, 741.201, 741.220,
 13 741.222, 741.250, 741.255, 741.300, 741.310, 741.340, 741.381. 741.390, 741.500, 741.510, 741.520,
 14 741.540, 741.900, 743.822, 743.826 and 746.222 and sections 1, 2, 3, 4 and 5, chapter 47, Oregon
 15 Laws 2010, by section 100 of this 2013 Act become operative January 1, 2017.

16 **SECTION 103.** This 2013 Act being necessary for the immediate preservation of the public
 17 peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect
 18 on its passage.

19