A-Engrossed
House Bill 2116

Ordered by the House April 27
Including House Amendments dated April 27

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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.

Creates Health System Fund to fund medical assistance and **private health option and to** pay refunds of hospital assessment. Modifies hospital assessment. Repeals sunset on hospital assessment. Directs hospital assessment to be paid into Health System Fund after October 1, 2009.

Creates assessment on insurance premiums to be administered by Department of Consumer and Business Services. Directs assessments minus specified amounts to be paid into Health System Fund.

Creates assessment on capitation payments to Medicaid managed care plans to be administered by Department of Human Services. Directs assessments to be deposited in Health System Fund.

Imposes penalties for failure to timely pay assessments.

Establishes Health Care for All Oregon Children program for purpose of providing affordable, accessible health care to all Oregon children. Specifies qualifications for program.

Directs Department of Human Services to provide medical assistance to specified persons for whom a public agency assumed financial responsibility.

Directs Office of Private Health Partnerships to administer private health option for purposes of expanding private health insurance coverage of Oregon's children.

Directs Department of Human Services to seek federal financial participation for programs relating to health care of Oregon's children. Specifies other duties of department relating to programs.

Establishes Private Health Option Program Fund. Continuously appropriates moneys in fund to Office of Private Health Partnerships for purposes of administering programs relating to health care of Oregon's children.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to health care assessment; creating new provisions; amending ORS 414.047, 414.536, 414.706, 414.839, 731.292, 731.840 and 735.701 and sections 2, 8, 10, 14 and 51, chapter 736, Oregon Laws 2003; repealing sections 9, 12 and 13, chapter 736, Oregon Laws 2003; appropriating money; prescribing an effective date; and providing for revenue raising that requires approval by a three-fifths majority.

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

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

(2) Amounts in the Health System Fund are continuously appropriated to the Department of Human Services for the purpose of paying refunds due under sections 6 and 41, chapter 736, Oregon Laws 2003, funding the private health option described in section 29 of this 2009 Act and funding medical assistance as defined in ORS 414.025, which may include but is not limited to:

(a) Increasing reimbursement rates for providers of health services under ORS 414.705

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.

to 414.750 above the rates that were in effect for those services on February 29, 2004;

(b) Expanding, continuing or modifying health services for persons described in ORS 414.706 (5); and

(c) Paying administrative costs incurred by the department to administer the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) The Department of Human Services shall develop a system for reimbursement by the department to the Office of Private Health Partnerships out of the Health System Fund for costs associated with administering the private health option pursuant to section 29 of this 2009 Act.

SECTION 2. Sections 3 to 5 of this 2009 Act are added to and made a part of the Insurance Code.

SECTION 3. As used in this section and sections 4 and 5 of this 2009 Act:

(1) "Gross amount of premiums" has the meaning given that term in ORS 731.808.

(2) "Health benefit plan" has the meaning given that term in ORS 743.730.

(3) "Insurer" means an authorized insurer that issues or renews a health benefit plan in this state.

SECTION 4. (1) No later than 45 days following the end of a calendar quarter, an insurer shall pay an assessment at the rate of _____ percent of the gross amount of premiums that were derived from health benefit plans covering direct domestic risks during that calendar quarter.

(2) The assessment shall be paid to the Department of Consumer and Business Services and shall be accompanied by a verified report, on a form prescribed by the department, of:

(a) All health benefit plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid; and

(b) The gross amount of premiums by line of insurance, derived by the insurer from all health benefit plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid.

(3) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on an insurer.

(4) An insurer may not offset the assessment under this section against corporate excise taxes imposed under ORS chapter 317.

(5) Assessments under this section may not be considered in the gross amount of premiums for any purpose.

(6) If the department determines that the assessment paid by the insurer under this section is incorrect, the department shall charge or credit to the insurer the difference between the correct amount of the assessment and the amount paid by the insurer.

SECTION 5. (1) An insurer that fails to timely file a verified report or to pay an assessment under section 4 of this 2009 Act shall be subject to a penalty of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.

(2) Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under section 4 of this 2009 Act.

SECTION 6. Sections 4 and 5 of this 2009 Act apply to premiums received by an insurer on or after the calendar quarter ending December 31, 2009.

SECTION 7. (1) As used in this section, "Medicaid managed care plan" includes a prepaid

capitated health service contractor described in ORS 414.630 and a prepaid managed care health services organization described in ORS 414.725.

(2) No later than 45 days following the end of a calendar quarter, a Medicaid managed care plan shall pay an assessment at a rate of _____ percent of the gross amount of capitation payments received by the Medicaid managed care plan during that calendar quarter for providing coverage of health services under ORS 414.705 to 414.750.

(3) The assessment shall be paid to the Department of Human Services in a manner and form prescribed by the department.

(4) Assessments received by the department under this section shall be deposited in the Health System Fund established in section 1 of this 2009 Act.

SECTION 8. (1) A Medicaid managed care plan that fails to timely pay an assessment under section 7 of this 2009 Act shall be subject to a penalty of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.

(2) Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under section 7 of this 2009 Act.

SECTION 9. Section 7 of this 2009 Act applies to capitation payments received by a Medicaid managed care plan on or after October 1, 2009.

SECTION 10. ORS 731.292 is amended to read:

731.292. (1) Except as provided in subsections (2)**,** [*and*] (3) **and (4)** of this section, all fees, charges and other moneys received by the Department of Consumer and Business Services or the Director of the Department of Consumer and Business Services under the Insurance Code shall be deposited in the fund created by ORS 705.145 and are continuously appropriated to the department for the payment of the expenses of the department in carrying out the Insurance Code.

(2) All taxes, fines and penalties paid pursuant to the Insurance Code shall be paid to the director and after deductions of refunds shall be paid by the director to the State Treasurer, at the end of every calendar month or more often in the director's discretion, for deposit in the General Fund to become available for general governmental expenses.

(3) All premium taxes received by the director pursuant to ORS 731.820 shall be paid by the director to the State Treasurer for deposit in the State Fire Marshal Fund.

(4) Assessments received by the department under section 4 of this 2009 Act shall be paid into the State Treasury and credited to the Health System Fund established in section 1 of this 2009 Act, after deducting the following amounts:

(a) Amounts needed to reimburse the department for expenses in administering sections 4 and 5 of this 2009 Act; and

(b) Amounts needed to reimburse the General Fund for reductions in revenue caused by the effect of section 4 of this 2009 Act on the retaliatory tax imposed under ORS 731.854 and 731.859.

NOTE: Section 11 was deleted by amendment. Subsequent sections were not renumbered.

SECTION 12. Section 2, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 2. (1) An assessment is imposed on each hospital in this state that is not a waivered hospital. The assessment shall be imposed at a rate determined by the Director of Human Services by rule that is the director's best estimate of the rate needed to fund the services and costs identified in section 9, chapter 736, Oregon Laws 2003. The rate of assessment shall be imposed on the net

revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

(2) Notwithstanding subsection (1) of this section, the rate of assessment may not exceed 1.5 percent.

(3) The assessment shall be reported on a form prescribed by the Department of Human Services and shall contain the information required to be reported by the department. The assessment form shall be filed with the department on or before the 75th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection (7) of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

(4) To the extent permitted by federal law, aggregate taxes levied under this section may not exceed payments under [*section 9 (2), chapter 736, Oregon Laws 2003*] **section 1 (2) of this 2009 Act**.

(5) Notwithstanding subsection (4) of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

(6) Hospitals operated by the United States Department of Veterans Affairs and pediatric specialty hospitals providing care to children at no charge are exempt from the assessment imposed under this section.

[*(7)(a) The Department of Human Services shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, 2009, that will result in the collection occurring between December 15, 2009, and the time all Medicaid cost settlements are finalized for that calendar quarter.*]

[*(b)*] **(7)** The Department of Human Services shall prescribe by rule criteria for late payment of assessments.

NOTE: Section 13 was deleted by amendment. Subsequent sections were not renumbered.

SECTION 14. Section 8, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 757, Oregon Laws 2005, is amended to read:

Sec. 8. Amounts collected by the Department of Human Services from the assessments imposed under section 2, chapter 736, Oregon Laws 2003, shall be deposited in the [*Hospital Quality Assurance Fund established under section 9, chapter 736, Oregon Laws 2003.*] **Health System Fund established in section 1 of this 2009 Act.**

SECTION 15. Section 10, chapter 736, Oregon Laws 2003, as amended by section 3, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 10. Sections 1 to 9, chapter 736, Oregon Laws 2003, apply to net revenues earned by hospitals on or after [*January 1, 2004, and before the earlier of October 1, 2009, or when the assessment described in sections 37 to 44, chapter 736, Oregon Laws 2003, no longer qualifies for federal matching funds under Title XIX of the Social Security Act.*] **October 1, 2009.**

SECTION 16. Section 14, chapter 736, Oregon Laws 2003, as amended by section 6, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 14. Any moneys remaining in the Hospital Quality Assurance Fund on [*December 31, 2013*] **October 1, 2009**, are transferred to the [*General Fund.*] **Health System Fund established in section 1 of this 2009 Act.**

SECTION 17. Section 51, chapter 736, Oregon Laws 2003, as amended by section 20, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 51. Any moneys [*remaining*] **deposited** in the Medical Care Quality Assurance Fund [*on*

December 31, 2011, are] **shall be** transferred to the [*General Fund*] **Health System Fund established in section 1 of this 2009 Act**.

SECTION 18. ORS 731.840 is amended to read:

731.840. (1) The retaliatory tax imposed upon a foreign or alien insurer under ORS 731.854 and 731.859, or the corporate excise tax imposed upon a foreign or alien insurer under ORS chapter 317, is in lieu of all other state taxes upon premiums, taxes upon income, franchise or other taxes measured by income that might otherwise be imposed upon the foreign or alien insurer except the fire insurance premiums tax imposed under ORS 731.820**,** [*and*] the tax imposed upon wet marine and transportation insurers under ORS 731.824 and 731.828**, and the assessment imposed under section 4 of this 2009 Act**. However, all real and personal property, if any, of the insurer shall be listed, assessed and taxed the same as real and personal property of like character of noninsurers. Nothing in this subsection shall be construed to preclude the imposition of the assessments imposed under ORS 656.612 upon a foreign or alien insurer.

(2) Subsection (1) of this section applies to a reciprocal insurer and its attorney in its capacity as such.

(3) Subsection (1) of this section applies to foreign or alien title insurers and to foreign or alien wet marine and transportation insurers issuing policies and subject to taxes referred to in ORS 731.824 and 731.828.

(4) The State of Oregon hereby preempts the field of regulating or of imposing excise, privilege, franchise, income, license, permit, registration, and similar taxes, licenses and fees upon insurers and their insurance producers and other representatives as such, and:

(a) No county, city, district, or other political subdivision or agency in this state shall so regulate, or shall levy upon insurers, or upon their insurance producers and representatives as such, any such tax, license or fee; except that whenever a county, city, district or other political subdivision levies or imposes generally on a nondiscriminatory basis throughout the jurisdiction of the taxing authority a payroll, excise or income tax, as otherwise provided by law, such tax may be levied or imposed upon domestic insurers; and

(b) No county, city, district, political subdivision or agency in this state shall require of any insurer, insurance producer or representative, duly authorized or licensed as such under the Insurance Code, any additional authorization, license, or permit of any kind for conducting therein transactions otherwise lawful under the authority or license granted under this code.

SECTION 19. (1) Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, and section 2, chapter 780, Oregon Laws 2007, is repealed.

(2) Section 12, chapter 736, Oregon Laws 2003, as amended by section 4, chapter 780, Oregon Laws 2007, is repealed.

(3) Section 13, chapter 736, Oregon Laws 2003, as amended by section 5, chapter 780, Oregon Laws 2007, is repealed.

SECTION 20. Sections 1 to 9 of this 2009 Act, the amendments to ORS 731.292 and 731.840 and sections 2, 8, 10, 14 and 51, chapter 736, Oregon Laws 2003, by sections 10, 12 and 14 to 18 of this 2009 Act and the repeal of sections 9, 12 and 13, chapter 736, Oregon Laws 2003, by section 19 of this 2009 Act become operative on October 1, 2009.

SECTION 21. Section 1 of this 2009 Act is amended to read:

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

(2) Amounts in the Health System Fund are continuously appropriated to the Department of

Human Services for the purpose of paying refunds due under [*sections 6 and 41*] **section 6**, chapter 736, Oregon Laws 2003, funding the private health option described in section 29 of this 2009 Act and funding medical assistance as defined in ORS 414.025, which may include but is not limited to:

(a) Increasing reimbursement rates for providers of health services under ORS 414.705 to 414.750 above the rates that were in effect for those services on February 29, 2004;

(b) Expanding, continuing or modifying health services for persons described in ORS 414.706 (5); and

(c) Paying administrative costs incurred by the department to administer the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) The Department of Human Services shall develop a system for reimbursement by the department to the Office of Private Health Partnerships out of the Health System Fund for costs associated with administering the private health option pursuant to section 29 of this 2009 Act.

SECTION 22. The amendments to section 1 of this 2009 Act by section 21 of this 2009 Act become operative on January 1, 2012.

SECTION 23. Sections 24, 25, 27 and 28 of this 2009 Act are added to and made a part of ORS chapter 414.

SECTION 24. As used in sections 25 and 27 of this 2009 Act:

(1) "Child" means a person under 19 years of age.

(2) "Health benefit plan" has the meaning given that term in ORS 735.720.

SECTION 25. (1) The Health Care for All Oregon Children program is established to make affordable, accessible health care available to all of Oregon's children. The program is composed of:

(a) Medical assistance funded in whole or in part by Title XIX of the Social Security Act, by the State Children's Health Insurance Program under Title XXI of the Social Security Act and by moneys appropriated or allocated for that purpose by the Legislative Assembly; and

(b) A private health option administered by the Office of Private Health Partnerships under section 29 of this 2009 Act.

(2) A child is eligible for the program if the child is lawfully present in this state and the income of the child's family is at or below 200 percent of the federal poverty guidelines. There is no asset limit to qualify for the program.

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

(b) The Department of Human Services shall reenroll a child for successive 12-month periods as long as the child remains eligible.

(4) Except for medical assistance funded by Title XIX of the Social Security Act and except as provided in section 27 of this 2009 Act, the department may prescribe by rule a period of uninsurance prior to enrollment in the program.

SECTION 26. Section 25 of this 2009 Act is amended to read:

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

(a) Medical assistance funded in whole or in part by Title XIX of the Social Security Act, by the State Children's Health Insurance Program under Title XXI of the Social Security Act and by moneys appropriated or allocated for that purpose by the Legislative Assembly; and

(b) A private health option administered by the Office of Private Health Partnerships under

section 29 of this 2009 Act.

(2) A child is eligible for the program if the child is lawfully present in this state and the income of the child's family is at or below [*200*] **300** percent of the federal poverty guidelines. There is no asset limit to qualify for the program.

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

(b) The Department of Human Services shall reenroll a child for successive 12-month periods as long as the child remains eligible.

(4) Except for medical assistance funded by Title XIX of the Social Security Act and except as provided in section 27 of this 2009 Act, the department may prescribe by rule a period of uninsurance prior to enrollment in the program.

SECTION 27. (1) A child qualifies for the Health Care for All Oregon Children program if the child has:

(a) A disability as defined in the federal Supplemental Security Income program;

(b) Family income or resources that exceed the allowable limits for federal Supplemental Security Income; and

(c) Family income at or below 300 percent of the federal poverty guidelines.

(2) A child who qualifies for the program pursuant to this section who has access to coverage under an employer sponsored health benefit plan for which the employer pays 40 percent or more of the total cost of premiums, must enroll in the employer sponsored health benefit plan.

(3) The Department of Human Services may not require a period of uninsurance prior to enrollment of a child who meets the requirements of this section.

(4) If the family income of the child is at or below 200 percent of the federal poverty guidelines, the department shall:

(a) Pay the employee share of the premium for an employer sponsored health benefit plan and shall pay copayments, deductibles and other employee cost-sharing in full; or

(b) If the child does not have access to coverage under an employer sponsored health benefit plan, the child shall be enrolled in medical assistance.

(5) If the family income of the child is above 200 percent but at or below 300 percent of the federal poverty guidelines, the department shall:

(a) Pay a portion of the employee cost of the premium on a sliding scale basis for an employer sponsored health benefit plan available to the child and shall pay the copayments, deductibles and other cost sharing in full; or

(b) If the child does not have access to coverage under an employer sponsored health benefit plan, the child shall be enrolled in medical assistance and shall pay a monthly premium to the department. The department shall prescribe by rule the amount of the premium, which may not exceed five percent of the family income.

SECTION 28. The Department of Human Services shall provide medical assistance to a person under 21 years of age who, on the person's 18th birthday, was in a foster family home or licensed child-caring agency or institution under a purchase of care agreement and, at that time, was a person for whom a public agency of this state assumed financial responsibility, in whole or in part, for medical assistance provided under ORS 414.706 and 414.707.

SECTION 29. (1) As used in this section:

(a) "Child" means a person under 19 years of age.

(b) "Health benefit plan" has the meaning given that term in ORS 735.720.

(2) The Office of Private Health Partnerships shall administer a private health option to expand access to private health insurance for Oregon's children.

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

(a) The health benefit plan meets or exceeds the requirements for a basic benchmark health benefit plan under ORS 735.733.

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

(c) The health benefit plan imposes copayments or other cost sharing that is based upon a family's ability to pay.

(d) Expenditures for the health benefit plan qualify for federal financial participation.

(4) The amount of premium assistance provided under this section shall be:

(a) Equal to the full cost of the premium for children whose family income is at or below 200 percent of the federal poverty guidelines and who have access to employer sponsored health insurance; and

(b) Based on a sliding scale under criteria established by the office by rule for children whose family income is above 200 percent but at or below 300 percent of the federal poverty guidelines, regardless of whether the child has access to coverage under an employer sponsored health benefit plan.

(5) A child whose family income is more than 300 percent of the federal poverty guidelines shall be offered the opportunity to purchase a health benefit plan through the private health option but may not receive premium assistance.

SECTION 30. Notwithstanding eligibility criteria and premium assistance amounts determined pursuant to section 29 of this 2009 Act, the Office of Private Health Partnerships shall provide premium assistance under the private health option to eligible children to the extent the Legislative Assembly appropriates funds for that purpose or establishes expenditure limitations to provide such premium assistance.

SECTION 31. (1) The Department of Human Services shall apply to the Centers for Medicare and Medicaid Services for any approval necessary to obtain federal financial participation in the costs of programs described in sections 25, 27, 28 and 29 of this 2009 Act.

(2) The department and the Office of Private Health Partnerships shall adopt rules implementing the Health Care for All Oregon Children program as soon as practicable after receipt of the necessary federal approval and may provide for implementation in stages in accordance with the availability of funding.

(3) Section 25 of this 2009 Act becomes operative on the later of October 1, 2009, or the date the Department of Human Services receives any federal approval required to secure federal financial participation under subsection (1) of this section.

(4) Sections 26 and 28 of this 2009 Act become operative on the later of January 1, 2010, or the date the Department of Human Services receives any federal approval required to secure federal financial participation under subsection (1) of this section.

(5) Section 27 of this 2009 Act becomes operative on the later of January 1, 2011, or the date the Department of Human Services receives any federal approval required to secure

federal financial participation under subsection (1) of this section.

SECTION 32. (1) There is established in the State Treasury, separate and distinct from the General Fund the Private Health Option Program Fund. The Private Health Option Program Fund consists of moneys transferred to the Office of Private Health Partnerships by the Department of Human Services under section 1 (3) of this 2009 Act. Interest earned by the fund shall be credited to the fund.

(2) Moneys in the Private Health Option Program Fund are continuously appropriated to the Office of Private Health Partnerships for carrying out sections 25 and 29 of this 2009 Act.

SECTION 33. (1) A prepaid managed care health services organization shall contract with a community health center or safety net clinic for the provision of covered services by the center or clinic to an enrollee of the organization participating in the Health Care for All Oregon Children program established under section 25 of this 2009 Act if the center or clinic agrees to similar contractual terms, conditions and reimbursement rates negotiated with subcontractors providing the same or similar services to the organization.

(2) As used in this section, "community health center or safety net clinic" means a nonprofit medical clinic that provides primary physical health, vision, dental or mental health services to low-income patients without charge or using a sliding fee scale based on the income of the patient. "Community health center or safety net clinic" includes a school-based health center.

SECTION 34. (1) The Department of Human Services shall award grants to community health centers and safety net clinics, as defined in section 33 of this 2009 Act, to ensure the capacity of each grantee to provide health care services to underserved or vulnerable populations, within the limits of funds provided by the Legislative Assembly for this purpose.

(2) The department shall provide outreach for the Health Care for All Oregon Children program, including development and administration of an application assistance program, and including grants to provide funding to organizations and local groups for outreach and enrollment activities for the program, within the limits of funds provided by the Legislative Assembly for this purpose.

(3) Notwithstanding subsections (1) and (2) of this section, the department shall provide funds for expansion and continuation of school-based health centers.

(4) The department shall by rule adopt criteria for awarding grants and providing funds under this section.

(5) The department shall analyze and evaluate the implementation of the Health Care for All Oregon Children program.

SECTION 35. (1) The Department of Human Services is responsible for statewide outreach and marketing of the medical assistance and premium assistance programs administered by the department and the Office of Private Health Partnerships with the goal of enrolling in those programs all eligible individuals residing in this state.

(2) To maximize the enrollment and retention of eligible individuals in the medical assistance and premium assistance programs, the department shall develop and administer a grant program to provide funding to organizations and community based groups to deliver culturally specific and targeted outreach and direct application assistance to:

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

(b) Individuals living in geographic isolation; and

(c) Individuals with additional barriers to accessing health care, such as individuals with

cognitive, mental health or sensory disorders, physical disabilities or chemical dependency and individuals experiencing homelessness.

SECTION 36. (1) The Department of Human Services shall implement a streamlined and simple application process for the medical assistance and premium assistance programs administered by the department and the Office of Private Health Partnerships. The process shall include, but not be limited to:

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

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

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

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

(3) The department shall facilitate outreach and enrollment efforts to connect eligible individuals with all available publicly funded health programs, including but not limited to the Family Health Insurance Assistance Program.

SECTION 37. (1) As used in this section, "qualified provider" means a person that:

(a) Is eligible for payment by the Department of Human Services for health services provided to recipients of medical assistance as defined in ORS 414.025;

(b)(A) Provides outpatient hospital services or other health services, as defined in ORS 414.705, that are offered by a rural health clinic in:

(i) A rural health clinic;

(ii) A federally-qualified health center; or

(iii) An Indian Health Service facility, a tribal health clinic or an urban Indian health center; or

(B) Provides clinic services under the direction of a physician, without regard to whether a physician is the administrator of the clinic;

(c) Is authorized by the department to make presumptive eligibility determinations; and

(d)(A) Receives funding from one or more of the following sources:

(i) Section 330 or 330A of the Public Health Service Act, 42 U.S.C. 254b or 254c;

(ii) Title V of the Social Security Act, 42 U.S.C. 701 et seq.; or

(iii) Title V of the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.;

(B) Participates in a program established under:

(i) Section 17 of the Child Nutrition Act of 1966, 42 U.S.C. 1786; or

(ii) Section 4(a) of the Agriculture and Consumer Protection Act of 1973, 7 U.S.C. 612c;

(C) Provides prenatal services paid for with funding from Title XIX or XXI of the Social Security Act; or

(D) Is the Indian Health Service or a health program or facility operated by a tribal organization under the Indian Self-Determination and Education Assistance Act, 25 U.S.C. 450f et seq.

(2) The department shall provide medical assistance to a pregnant woman, residing in this state, who is presumptively eligible for medical assistance as determined under ORS 414.536 or this section.

(3) A woman is presumptively eligible for medical assistance under this section if a qualified provider determines that the woman is pregnant and that her income does not exceed the limits established by the department by rule.

(4) The presumptive eligibility period for medical assistance begins on the date a qualified provider makes the determination under subsection (3) of this section and ends on the earlier of the following dates:

(a) If the woman timely files an application for medical assistance, the date the department determines eligibility for medical assistance in accordance with ORS 414.047.

(b) If the woman does not timely file an application for medical assistance, the last day of the month following the month in which the presumptive eligibility period begins.

(5) An application is timely filed under subsection (4) of this section if it is filed with the department on or before the last day of the month following the month in which the presumptive eligibility determination is made by a qualified provider under subsection (3) of this section.

(6) The department shall furnish to qualified providers medical assistance application forms and information about how to assist an applicant in completing and filing the forms.

(7) A qualified provider that makes a presumptive eligibility determination under subsection (3) of this section shall:

(a) Immediately inform the woman that she must file an application for medical assistance with the department on or before the last day of the month following the month in which the presumptive eligibility determination is made by a qualified provider;

(b) Provide a medical assistance application form to the woman;

(c) With the woman's consent, assist her in completing the application;

(d) Within five working days of the determination, notify the department; and

(e) Submit the completed application to the department.

SECTION 38. ORS 414.047 is amended to read:

414.047. (1) Application for any category of aid shall also constitute application for medical assistance.

(2) Except as [*otherwise*] provided in this section, each person requesting medical assistance shall [*make application therefor*] **apply** to the Department of Human Services. The department shall determine **the person's** eligibility for **assistance** and fix the date on which [*such*] **the** assistance [*may begin,*] **begins** and shall obtain [*such*] other information required by [*the rules of*] **rules adopted by** the department.

(3) If [*an applicant*] **a person** is unable to make application for medical assistance, an application may be made by someone acting responsibly for [*the applicant*] **that person**.

(4)(a) The department shall adopt rules establishing a minimum 12-month period of enrollment for persons described in 42 U.S.C. 1396a(l)(1)(C) or (D) who are determined eligible for medical assistance.

(b) The department shall reenroll a person immediately following the initial 12-month period of enrollment for successive 12-month periods of enrollment as long as the person meets the description in 42 U.S.C. 1396a(l)(1)(C) or (D) and is eligible for medical assistance on the date of reenrollment.

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

readily available to the person.

SECTION 39. ORS 414.536 is amended to read:

414.536. (1) **If** the Department of Human Services [*shall provide medical assistance to a woman whom the department determines is presumptively eligible for medical assistance. As used in this section, a woman is "presumptively eligible for medical assistance" if the department determines that the*] **determines that a** woman likely is eligible for medical assistance under ORS 414.534**, the department shall determine her to be presumptively eligible for medical assistance until a formal determination on eligibility is made**.

(2) The period of time a woman may receive medical assistance based on presumptive eligibility **under this section** is limited. The period of time:

(a) Begins on the date that the department determines the woman likely meets the eligibility criteria under ORS 414.534; and

(b) Ends on the earlier of the following dates:

(A) If the woman applies for medical assistance following the determination by the department that the woman is presumptively eligible for medical assistance, the date on which a formal determination on eligibility is made by the department in accordance with ORS 414.534; or

(B) If the woman does not apply for medical assistance following the determination by the department that the woman is presumptively eligible for medical assistance, the last day of the month following the month in which presumptive eligibility begins.

SECTION 40. ORS 414.706 is amended to read:

414.706. The Legislative Assembly shall approve and fund health services to the following persons:

(1) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o);

(2) Pregnant women with incomes no more than [*185*] **200** percent of the federal poverty guidelines;

(3) Persons under 19 years of age with incomes no more than 200 percent of the federal poverty guidelines;

(4) Persons described in ORS 414.708; and

(5) Persons 19 years of age or older with incomes no more than 100 percent of the federal poverty guidelines who do not have federal Medicare coverage.

SECTION 41. ORS 414.839 is amended to read:

414.839. [*(1)*] Subject to funds available, the Department of Human Services may provide [*public subsidies*] **premium assistance** for the purchase of health insurance coverage provided by public programs or private insurance, including but not limited to**:**

(1) The Family Health Insurance Assistance Program**;** [*, for currently uninsured individuals based on incomes up to 200 percent of the federal poverty level. The objective is to create a transition from dependence on public programs to privately financed health insurance.*]

[*(2) Public subsidies shall apply only to health benefit plans that meet or exceed the basic benchmark health benefit plan or plans established under ORS 735.733.*]

[*(3) Cost sharing shall be permitted and structured in such a manner to encourage appropriate use of preventive care and avoidance of unnecessary services.*]

[*(4) Cost sharing shall be based on an individual's ability to pay and may not exceed the cost of purchasing a plan.*]

[*(5) The state may pay a portion of the cost of the subsidy, based on the individual's income and other resources.*]

(2) Medical assistance described in ORS 414.115; and

(3) The Health Care for All Oregon Children program established in section 25 of this 2009 Act.

SECTION 42. ORS 735.701 is amended to read:

735.701. (1) The Office of Private Health Partnerships is established.

(2) The office shall carry out the duties described under ORS 414.831, 735.700 to 735.714 and 735.720 to 735.740 **and sections 25 and 29 of this 2009 Act**.

SECTION 43. This 2009 Act takes effect on the 91st day after the date on which the regular session of the Seventy-fifth Legislative Assembly adjourns sine die.