C-Engrossed
House Bill 2116

Ordered by the House June 1
Including House Amendments dated April 27 and May 28 and June 1

Ordered printed by the Speaker pursuant to House Rule 12.00A (5). Presession filed (at the request of Governor Theodore R. Kulongoski)

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 for specified purposes, including funding of Health Care for All Oregon Children program. Modifies hospital assessment. Extends sunset on hospital assessment.

Transfers moneys in Medical Care Quality Assurance Fund to Health System Fund on specified date.

Creates assessment on medical claims received by Public Employees' Benefit Board. Directs assessment to be paid to Department of Consumer and Business Services.

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.

Directs Department of Human Services to establish adjustment to capitation rate paid to certain Medicaid managed care organizations. Requires contracts between department and organizations to distribute adjustment to specified hospitals.

Directs Department of Human Services to establish fee-for-service reimbursement rates for inpatient hospital services provided by certain hospitals that receive Medicare reimbursement.

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

Directs Office of Private Health Partnerships to administer private health option for purposes of expanding private health insurance for 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.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to health care assessment; creating new provisions; amending ORS 192.519, 291.055, 411.708, 414.025, 414.042, 414.428, 414.706, 414.707, 414.710, 414.712, 414.736, 414.839, 731.036, 731.292, 731.840 and 735.701 and sections 2, 5, 9, 10, 12, 13, 14 and 51, 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 funding the Health Care for All Oregon Children program established in section 27 of this 2009 Act, health services described in ORS 414.705 (1)(a) to (j) and other health services. Moneys in the fund may also be used by the department to:

(a) Provide grants to community health centers and safety net clinics under section 33

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.

of this 2009 Act.

(b) Pay refunds due under section 41, chapter 736, Oregon Laws 2003, and under section 11 of this 2009 Act.

(c) Pay administrative costs incurred by the department to administer the assessment in section 9 of this 2009 Act.

(3) The department 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 30 of this 2009 Act.

SECTION 2. Sections 3 to 7 of this 2009 Act are added to and made a part of the Insurance Code.

SECTION 3. (1) As used in this section:

(a) "Insured" means an eligible employee or family member, as defined in ORS 243.105, who is covered by a self-insured health benefit plan under ORS 243.105 to 243.285.

(b) "Medical claim" means a request to a self-insured health benefit plan for payment for a health care item or service provided to an insured, other than a dental or vision care item or service.

(2) No later than 45 days following the end of a calendar quarter, the Public Employees' Benefit Board shall pay an assessment at the rate of one percent of all medical claims received and the administrative costs associated with the claims received during the calendar quarter.

(3) 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, together with any information required by the department.

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

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

(6) The board is entitled to notice and an opportunity for a contested case hearing under ORS chapter 183 to contest an action of the department taken pursuant to subsection (5) of this section.

(7) The assessment paid by the board under this section shall be considered part of the board's administrative expenses.

SECTION 3a. Section 3 of this 2009 Act applies to medical claims received by the Public Employees' Benefit Board, or a person that contracts with the board to pay medical claims under a self-insured health benefit plan, during the period from October 1, 2009, through September 30, 2013.

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

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

(2) "Health plan" means health insurance and insurance provided by a health care service contractor as defined in ORS 750.005, excluding:

(a) Insurance policies covering vision only or dental only benefits;

(b) Medicare advantage plans;

(c) Medicare Part D plans;

(d) Long term care insurance;

(e) Health insurance issued to federal employees that is exempt from state taxes under federal law;

(f) A policy of stop-loss coverage that meets the requirements of ORS 742.065;

(g) Insurance policies issued to supplement liability insurance coverage;

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

(i) Reinsurance as defined in ORS 731.126;

(j) Workers compensation insurance; and

(k) Disability insurance.

SECTION 5. (1) No later than 45 days following the end of a calendar quarter, an insurer shall pay an assessment at the rate of one percent of the gross amount of premiums earned by the insurer during that calendar quarter that were derived from health plan policies:

(a) Insuring Oregon residents; or

(b) Delivered or issued for delivery in Oregon.

(2) The assessment shall be paid to the Department of Consumer and Business Services and shall be accompanied by a verified form prescribed by the department together with any information required by the department, that reports:

(a) All health 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 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) Any rate filed for the department's approval may include amounts paid by the insurer under this section as a valid element of administrative expense or retention.

SECTION 6. (1) If the Public Employees' Benefit Board or an insurer fails to timely file a verified form or to pay an assessment required under section 3 or 5 of this 2009 Act, the insurer or the board 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 sections 3 and 5 of this 2009 Act.

SECTION 7. (1) If the Department of Consumer and Business Services determines that the assessment paid by the insurer under section 5 of this 2009 Act 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.

(2) An insurer that is aggrieved by an action of the department taken pursuant to subsection (1) of this section shall be entitled to notice and an opportunity for a contested case hearing under ORS chapter 183.

SECTION 8. (1) Sections 5 and 6 of this 2009 Act apply to premiums earned by an insurer during the period from October 1, 2009, through September 30, 2013.

(2) Notwithstanding any provision of contract or statute, including ORS 743.737 and 743.767, beginning October 1, 2009, insurers may include in their rates an additional one

percent of the existing rate. To the extent the existing rate was approved by the Department of Consumer and Business Services, the resulting rate, including the additional one percent, shall be considered an approved rate. If an insurer increases its rates under this subsection, the insurer shall include in all consumer billings a notice explaining the increase in a form prescribed by the department. This subsection applies to any rate approved by or filed for the department's approval prior to the effective date of this 2009 Act and to any contract of insurance not subject to the department's rate approval authority.

SECTION 9. (1) As used in this section, "Medicaid managed care organization" means the following entities defined in or referred to in ORS 414.736:

(a) A fully capitated health plan.

(b) A physician care organization.

(c) A mental health organization.

(2) No later than 45 days following the end of a calendar quarter, a Medicaid managed care organization shall pay an assessment at a rate of one percent of the gross amount of capitation payments received by the Medicaid managed care organization 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.

(5) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on a Medicaid managed care organization.

SECTION 10. (1) A Medicaid managed care organization that fails to timely pay an assessment under section 9 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 9 of this 2009 Act.

SECTION 11. (1) A Medicaid managed care organization that has paid an amount that is not required under section 9 of this 2009 Act may file a claim for refund with the Department of Human Services.

(2) Any Medicaid managed care organization that is aggrieved by an action of the department taken pursuant to subsection (1) of this section shall be entitled to notice and an opportunity for a contested case hearing under ORS chapter 183.

SECTION 12. Sections 9, 10 and 11 of this 2009 Act apply to capitation payments earned by a Medicaid managed care organization during the period from October 1, 2009, through September 30, 2013.

SECTION 13. 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 sections 3 and 5 of this 2009 Act and penalties received by the department under sections 6 and 10 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 3 to 7 of this 2009 Act; and

(b) Amounts needed to reimburse the General Fund for reductions in revenue caused by the effect of section 5 of this 2009 Act on the retaliatory tax imposed under ORS 731.854 and 731.859.

SECTION 14. Sections 15 and 16 of this 2009 Act are added to and made a part of ORS 414.705 to 414.750.

SECTION 15. (1) The Department of Human Services shall establish an adjustment to the capitation rate paid to a Medicaid managed care organization defined in section 9 of this 2009 Act.

(2) The contracts entered into between the department and Medicaid managed care organizations must include provisions that ensure that the adjustment to the capitation rate established under subsection (1) of this section is distributed by the Medicaid managed care organizations to hospitals located in Oregon that receive Medicare reimbursement based upon diagnostic related groups.

(3) The adjustment to the capitation rate paid to Medicaid managed care organizations shall be established in an amount consistent with the legislatively adopted budget and the aggregate assessment imposed pursuant to section 2, chapter 736, Oregon Laws 2003.

SECTION 16. The Department of Human Services shall promptly seek federal approval necessary to obtain federal financial participation in the costs of programs and services funded with assessments paid under sections 3, 5 and 9 of this 2009 Act.

SECTION 17. 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 **the net revenue of** 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)*] **(2)** 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)*] **(6)** 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)*] **(3)(a)** To the extent permitted by federal law, aggregate [*taxes levied*] **assessments imposed** under this section may not exceed [*payments under section 9 (2), chapter 736, Oregon Laws 2003.*] **the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:**

(A) The adjustment to the capitation rate paid to Medicaid managed care organizations under section 15 of this 2009 Act;

(B) 30 percent of payments made to hospitals on a fee-for-service basis by the department for inpatient hospital services; and

(C) 41 percent of payments made to hospitals on a fee-for-service basis by the department for outpatient hospital services.

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed for the biennium beginning July 1, 2009, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for that biennium for hospital services under ORS 414.705 to 414.750.

[*(5)*] **(4)** Notwithstanding subsection [*(4)*] **(3)** 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)*] **(5)** 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)*] **(6)(a)** The Department of Human Services shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, [*2009*] **2013**, that will result in the collection occurring between December 15, [*2009*] **2013**, and the time all Medicaid cost settlements are finalized for that calendar quarter.

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

SECTION 18. Section 5, chapter 736, Oregon Laws 2003, is amended to read:

Sec. 5. (1) A hospital that fails to file a report or pay an assessment under section 2**, chapter 736, Oregon Laws 2003,** [*of this 2003 Act*] by the date the report or payment is due shall be subject to a penalty of **up to** $500 per day of delinquency. The total amount of penalties imposed under this section for each reporting period may not exceed five percent of the assessment for the reporting period for which penalties are being imposed.

(2) Penalties imposed under this section shall be collected by the Department of Human Services and deposited in the Department of Human Services Account established under ORS 409.060.

(3) Penalties paid under this section are in addition to and not in lieu of the assessment imposed under section 2**, chapter 736, Oregon Laws 2003** [*of this 2003 Act*].

SECTION 19. Section 9, chapter 736, Oregon Laws 2003, as amended by section 3, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 9. (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Department of Human Services for the purpose of paying refunds due under section 6, chapter 736, Oregon Laws 2003, and funding [*hospital*] services under ORS 414.705 to 414.750, including but not

limited to:

(a) Increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.705 to 414.750 [*above the rates that were in effect for those services on February 29, 2004*];

(b) **Maintaining,** expanding[*, continuing*] or modifying [*hospital*] services for persons described in ORS [*414.706 (5)*] **414.025 (2)(s)**;

(c) Maintaining or increasing the number of persons described in ORS 414.025 (2)(s) who are enrolled in the medical assistance program; and

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

(3) **Except for assessments imposed pursuant to section 2 (3)(b), chapter 736, Oregon Laws 2003,** the department may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

SECTION 20. 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 **during a period beginning October 1, 2009, and ending the earlier of September 30, 2013, or the date on which the assessment** [*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.

SECTION 21. Section 12, chapter 736, Oregon Laws 2003, as amended by section 4, chapter 780, Oregon Laws 2007 is amended to read:

Sec. 12. Sections 1 to 9, chapter 736, Oregon Laws 2003, are repealed on January 2, [*2012*] **2015**.

SECTION 22. Section 13, chapter 736, Oregon Laws 2003, as amended by section 5, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 13. Nothing in the repeal of sections 1 to 9, chapter 736, Oregon Laws 2003, by section 12, chapter 736, Oregon Laws 2003, affects the imposition and collection of a hospital assessment under sections 1 to 9, chapter 736, Oregon Laws 2003, for a calendar quarter beginning before September 30, [*2009*] **2013**.

SECTION 23. 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*] **2017**, are transferred to the General Fund.

SECTION 24. 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*] in the Medical Care Quality Assurance Fund [*on December 31, 2011, are*] **on or after October 1, 2009, shall be** transferred to the [*General Fund*] **Health System Fund established in section 1 of this 2009 Act**.

SECTION 25. 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 5 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 26. Sections 27 and 29 of this 2009 Act are added to and made a part of ORS chapter 414.

SECTION 27. (1) As used in this section, "child" means a person under 19 years of age.

(2) 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 30 of this 2009 Act.

(3) 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.

(4)(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 of enrollment as long as the child 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 child's eligibility for medical assistance using information and sources available to the department or documentation

readily available.

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

SECTION 28. Section 27 of this 2009 Act is amended to read:

Sec. 27. (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 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 30 of this 2009 Act.

(3) 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.

(4)(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 of enrollment as long as the child 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.

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

SECTION 29. The Department of Human Services shall establish fee-for-service reimbursement rates for inpatient hospital services provided by hospitals that receive Medicare reimbursement on the basis of diagnostic related groups as follows:

(1) For the period from October 1, 2009, through September 30, 2013, at the same rate paid by Medicare on the date of the service.

(2) For the period beginning October 1, 2013, at a rate that is 70 percent of the rate paid by Medicare on the date of the service.

SECTION 30. (1) As used in this section:

(a) "Child" means a person under 19 years of age who is lawfully present in this state.

(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 31. Notwithstanding eligibility criteria and premium assistance amounts determined pursuant to section 30 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 32. (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 27 and 30 of this 2009 Act, and in implementing the amendment to section 27 of this 2009 Act by section 28 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 27 of this 2009 Act becomes operative on the later of October 1, 2009, or the date on which the Department of Human Services receives any federal approval required to secure federal financial participation under subsection (1) of this section.

(4) Section 30 of this 2009 Act and the amendments to section 27 of this 2009 Act by section 28 of this 2009 Act become operative on the later of January 1, 2010, or the date on which the Department of Human Services receives any federal approval required to secure federal financial participation under subsection (1) of this section.

SECTION 33. (1) As used in this section, "community health center or safety net clinic" means a nonprofit medical clinic or school-based health center that provides primary physical health, vision, dental or mental health services to low-income patients without charge or using a sliding scale based on the income of the patient.

(2) The Department of Human Services shall award grants to community health centers or safety net clinics 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.

(3) 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.

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

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

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

SECTION 34. (1) The Department of Human Services is responsible for statewide outreach and marketing of the Health Care for All Oregon Children program established in section 27 of this 2009 Act and administered by the department and the Office of Private Health Partnerships with the goal of enrolling in those programs all eligible children residing in this state.

(2) To maximize the enrollment and retention of eligible children in the Health Care for All Oregon Children program, 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) Children living in geographic isolation; and

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

SECTION 35. (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 36. ORS 414.025, as amended by section 18a, chapter 861, Oregon Laws 2007, is amended to read:

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

(1) "Category of aid" means assistance provided by the Oregon Supplemental Income Program,

aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

(2) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for[,] **a category of aid** but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child as defined in ORS 412.001 except for age and regular attendance in school or in a course of professional or technical training.

(e)(A) Is a caretaker relative, as defined in ORS 412.001, who cares for a child who would be a dependent child except for age and regular attendance in school or in a course of professional or technical training; or

(B) Is the spouse of the caretaker relative.

(f) Is under the age of 21 years, is in a foster family home or licensed child-caring agency or institution under a purchase of care agreement and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Department of Human Services to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative as defined in ORS 412.001 who cares for a dependent child receiving aid granted under ORS 412.001 to 412.069 and 418.647 or is the spouse of the caretaker relative.

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for persons with mental retardation[*; or*]**.**

(k) Is under the age of 22 years and is in a psychiatric hospital.

[*(k)*] **(L)** Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by the Department of Human Services.

[*(L)*] **(m)** Is a member of a family that received aid in the preceding month under ORS 412.006 or 412.014 and became ineligible for aid due to increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of at least six calendar months beginning with the month in which such family became ineligible for assistance due to increased hours of employment or increased earnings.

[*(m)*] **(n)** Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

[*(n)*] **(o)** Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

[*(o)*] **(p)** Is an individual or member of a group who, subject to the rules of the department [*and within available funds*], may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

[*(p)*] **(q)** Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to

412.069 and 418.647, whether or not the woman is eligible for cash assistance.

[*(q)*] **(r)** Except as otherwise provided in this section [*and to the extent of available funds*], is a pregnant woman or child for whom federal financial participation is available under Title XIX **or XXI** of the federal Social Security Act.

[*(r)*] **(s)** Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act or is not a full-time student in a post-secondary education program as defined by the Department of Human Services by rule, but whose family income is less than the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department by rule.

[*(s)*] **(t)** Would be eligible for a category of aid but for the receipt of qualified long term care insurance benefits under a policy or certificate issued on or after January 1, 2008. As used in this paragraph, "qualified long term care insurance" means a policy or certificate of insurance as defined in ORS 743.652 (6).

(u) Is eligible for the Health Care for All Oregon Children program established in section 27 of this 2009 Act.

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

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

(5) "Medical assistance" means so much of the following medical and remedial care and services as may be prescribed by the Department of Human Services according to the standards established pursuant to ORS 414.065, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

(a) Inpatient hospital services, other than services in an institution for mental diseases;

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

(d) Skilled nursing facility services, other than services in an institution for mental diseases;

(e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;

(f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

(L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter 689;

(m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(n) Other diagnostic, screening, preventive and rehabilitative services;

(o) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(p) Any other medical care, and any other type of remedial care recognized under state law;

(q) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental impairments, and such health care, treatment and other measures to correct or ameliorate impairments and chronic conditions discovered thereby;

(r) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases; and

(s) Hospice services.

(6) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. "Medical assistance" includes "health services" as defined in ORS 414.705. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(7) "Medically needy" means a person who is a resident of this state and who is considered eligible under federal law for medically needy assistance.

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

SECTION 37. 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)(o) and (p)**;

(2) Pregnant women with incomes no more than 185 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 38. ORS 414.839 is amended to read:

414.839. [*(1)*] Subject to funds available, the Department of Human Services may provide [*public subsidies*] **medical assistance in the form of 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 27 of this 2009

Act.

SECTION 39. ORS 192.519 is amended to read:

192.519. As used in ORS 192.518 to 192.529:

(1) "Authorization" means a document written in plain language that contains at least the following:

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

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

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

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

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

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

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

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

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

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

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

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

(2) "Covered entity" means:

(a) A state health plan;

(b) A health insurer;

(c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.518 to 192.529; or

(d) A health care clearinghouse.

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

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

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

(b) Case management and care coordination;

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

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating de-identified information; and

(j) Fundraising.

(5) "Health care provider" includes but is not limited to:

(a) A psychologist, occupational therapist, clinical social worker, professional counselor or marriage and family therapist licensed under ORS chapter 675 or an employee of the psychologist, occupational therapist, clinical social worker, professional counselor or marriage and family therapist;

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

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

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

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

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

(g) An emergency medical technician certified under ORS chapter 682;

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

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

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

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

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

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

(n) A radiologic technologist licensed under ORS 688.405 to 688.605 or an employee of the radiologic technologist;

(o) A respiratory care practitioner licensed under ORS 688.800 to 688.840 or an employee of the respiratory care practitioner;

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

(q) A dietitian licensed under ORS 691.405 to 691.585 or an employee of the dietitian;

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

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

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

(u) A hospice program as defined in ORS 443.850;

(v) A clinical laboratory as defined in ORS 438.010;

(w) A pharmacy as defined in ORS 689.005;

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

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

(6) "Health information" means any oral or written information in any form or medium that:

(a) Is created or received by a covered entity, a public health authority, an employer, a life insurer, a school, a university or a health care provider that is not a covered entity; and

(b) Relates to:

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

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

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

(7) "Health insurer" means:

(a) An insurer as defined in ORS 731.106 who offers:

(A) A health benefit plan as defined in ORS 743.730;

(B) A short term health insurance policy, the duration of which does not exceed six months including renewals;

(C) A student health insurance policy;

(D) A Medicare supplemental policy; or

(E) A dental only policy.

(b) The Oregon Medical Insurance Pool operated by the Oregon Medical Insurance Pool Board under ORS 735.600 to 735.650.

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

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

(b) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

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

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

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

(9) "Payment" includes but is not limited to:

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(10) "Personal representative" includes but is not limited to:

(a) A person appointed as a guardian under ORS 125.305, 419B.370, 419C.481 or 419C.555 with authority to make medical and health care decisions;

(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or a representative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment decisions;

(c) A person appointed as a personal representative under ORS chapter 113; and

(d) A person described in ORS 192.526.

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

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

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

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

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

(12) "State health plan" means:

(a) [*The state Medicaid program*] **Medical assistance as defined in ORS 414.025**;

(b) The [*Oregon State Children's Health Insurance Program*] **Health Care for All Oregon Children program**; or

(c) The Family Health Insurance Assistance Program established in ORS 735.720 to 735.740.

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

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

(b) Consultations and referrals between health care providers.

SECTION 40. ORS 291.055 is amended to read:

291.055. (1) Notwithstanding any other law that grants to a state agency the authority to establish fees, all new state agency fees or fee increases adopted after July 1 of any odd-numbered year:

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

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

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

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

(e) Are rescinded on July 1 of the next following odd-numbered year, or on adjournment sine die of the regular session of the Legislative Assembly meeting in that year, whichever is later, unless otherwise authorized by enabling legislation setting forth the approved fees.

(2) This section does not apply to:

(a) Any tuition or fees charged by the State Board of Higher Education and state institutions of higher education.

(b) Taxes or other payments made or collected from employers for unemployment insurance required by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

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

(B) Assessments and premiums paid to the Oregon Medical Insurance Pool established by ORS 735.614 and 735.625.

(C) Copayments and premiums paid to the Oregon medical assistance program.

(D) Assessments paid to the Department of Consumer and Business Services under sections 3 and 5 of this 2009 Act.

(d) Fees created or authorized by statute that have no established rate or amount but are calculated for each separate instance for each fee payer and are based on actual cost of services provided.

(e) State agency charges on employees for benefits and services.

(f) Any intergovernmental charges.

(g) Forest protection district assessment rates established by ORS 477.210 to 477.265 and the Oregon Forest Land Protection Fund fees established by ORS 477.760.

(h) State Department of Energy assessments required by ORS 469.421 (8) and 469.681.

(i) Any charges established by the State Parks and Recreation Director in accordance with ORS 565.080 (3).

(j) Assessments on premiums charged by the Insurance Division of the Department of Consumer and Business Services pursuant to ORS 731.804 or fees charged by the Division of Finance and Corporate Securities of the Department of Consumer and Business Services to banks, trusts and credit unions pursuant to ORS 706.530 and 723.114.

(k) Public Utility Commission operating assessments required by ORS 756.310 or charges paid to the Residential Service Protection Fund required by chapter 290, Oregon Laws 1987.

(L) Fees charged by the Housing and Community Services Department for intellectual property pursuant to ORS 456.562.

(m) New or increased fees that are anticipated in the legislative budgeting process for an agency, revenues from which are included, explicitly or implicitly, in the legislatively adopted budget for the agency.

(n) Tolls approved by the Oregon Transportation Commission pursuant to ORS 383.004.

(3)(a) Fees temporarily decreased for competitive or promotional reasons or because of unexpected and temporary revenue surpluses may be increased to not more than their prior level without compliance with subsection (1) of this section if, at the time the fee is decreased, the state agency specifies the following:

(A) The reason for the fee decrease; and

(B) The conditions under which the fee will be increased to not more than its prior level.

(b) Fees that are decreased for reasons other than those described in paragraph (a) of this subsection may not be subsequently increased except as allowed by ORS 291.050 to 291.060 and 294.160.

SECTION 41. ORS 411.708 is amended to read:

411.708. (1) The amount of any assistance paid under ORS 411.706 is a claim against the property or interest in the property belonging to and a part of the estate of any deceased recipient. If the deceased recipient has no estate, the estate of the surviving spouse of the deceased recipient, if any, shall be charged for assistance granted under ORS 411.706 to the deceased recipient or the surviving spouse. There shall be no adjustment or recovery of assistance correctly paid on behalf of any deceased recipient under ORS 411.706 except after the death of the surviving spouse of the deceased recipient, if any, and only at a time when the deceased recipient has no surviving child who is under 21 years of age or who is blind or has a disability. Transfers of real or personal property by recipients of assistance without adequate consideration are voidable and may be set aside under ORS 411.620 (2).

(2) Except when there is a surviving spouse, or a surviving child who is under 21 years of age or who is blind or has a disability, the amount of any assistance paid under ORS 411.706 is a claim against the estate in any conservatorship proceedings and may be paid pursuant to ORS 125.495.

(3) A claim under this section shall exclude benefits paid to or on behalf of a beneficiary under a policy of qualified long term care insurance, as defined in ORS 414.025 [*(2)(s)*] **(2)(t)**.

(4) Nothing in this section authorizes the recovery of the amount of any assistance from the estate or surviving spouse of a recipient to the extent that the need for assistance resulted from a crime committed against the recipient.

SECTION 42. ORS 414.042 is amended to read:

414.042. (1) The need for and the amount of medical assistance to be made available for each eligible group of recipients of medical assistance shall be determined, in accordance with the rules of the Department of Human Services, taking into account:

(a) The requirements and needs of the person, the spouse and other dependents;

(b) The income, resources and maintenance available to the person but, except as provided in ORS 414.025 [*(2)(r)*] **(2)(s)**, resources shall be disregarded for those eligible by reason of having income below the federal poverty level and who are eligible for medical assistance only because of the enactment of chapter 836, Oregon Laws 1989;

(c) The responsibility of the spouse and, with respect to a person who is blind or is permanently and totally disabled or is under 21 years of age, the responsibility of the parents; and

(d) The report of the Health Services Commission as funded by the Legislative Assembly and such other programs as the Legislative Assembly may authorize. However, medical assistance, including health services, shall not be provided to persons described in ORS 414.025 [*(2)(r)*] **(2)(s)** unless the Legislative Assembly specifically appropriates funds to provide such assistance.

(2) Such amounts of income and resources may be disregarded as the department may prescribe by rules, except that the department may not require any needy person over 65 years of age, as a condition of entering or remaining in a hospital, nursing home or other congregate care facility, to sell any real property normally used as such person's home. Any rule of the department inconsistent with this section is to that extent invalid. The amounts to be disregarded shall be within the limits required or permitted by federal law, rules or orders applicable thereto.

(3) In the determination of the amount of medical assistance available to a medically needy person, all income and resources available to the person in excess of the amounts prescribed in ORS 414.038, within limits prescribed by the department, shall be applied first to costs of needed medical and remedial care and services not available under the medical assistance program and then to the costs of benefits under the medical assistance program.

SECTION 43. ORS 414.428 is amended to read:

414.428. (1) An individual described in ORS 414.025 [*(2)(r)*] **(2)(s)** who is eligible for or receiving medical assistance and who is an American Indian and Alaskan Native beneficiary shall receive the benefit package of health care services described in ORS [*414.835*] **414.707 (1)(a)** if:

(a) The Department of Human Services receives 100 percent federal medical assistance percentage for payments made by the department for the health care services provided as part of the benefit package described in ORS [*414.835*] **414.707 (1)(a)** that are not included in the benefit package described in ORS [*414.834*] **414.707 (3)**; or

(b) The department receives funding from the Indian tribes for which federal financial participation is available.

(2) As used in this section, "American Indian and Alaskan Native beneficiary" means:

(a) A member of a federally recognized Indian tribe, band or group;

(b) An Eskimo or Aleut or other Alaskan native enrolled by the United States Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601; or

(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose.

SECTION 44. ORS 414.707 is amended to read:

414.707. (1) Subject to funds available:

(a) Persons who are categorically needy as described in ORS 414.025 [*(2)(n) and (o)*] **(2)(o) and (p)**, and persons under 19 years of age and pregnant women who are eligible to receive health ser-

vices under ORS 414.706, are eligible to receive all the health services approved and funded by the Legislative Assembly.

(b) Persons described in ORS 414.708 are eligible to receive the health services described in ORS 414.705 (1)(c), (f) and (g).

(c) Persons 19 years of age and older who are eligible to receive health services under ORS 414.706 are eligible to receive the health services described in ORS 414.705 (1)(b) to (m).

(2) Persons who are categorically needy as described in ORS 414.025 [*(2)(n) and (o)*] **(2)(o) and (p)**, and persons under 19 years of age and pregnant women who are eligible to receive health services under ORS 414.706, must be provided, at a minimum, the health services described in ORS 414.705 (1)(a) to (g).

(3) Persons 19 years of age and older who are eligible to receive health services under ORS 414.706 must be provided, at a minimum, health services described in ORS 414.705 (1)(b) to (h).

(4) Persons described in ORS 414.708 must be provided, at a minimum, the health services described in ORS 414.705 (1)(c).

(5) The Department of Human Services shall:

(a) Develop at least three benefit packages of provider services to be offered under ORS 414.705 (1)(j); and

(b) Define by rule the services to be offered under ORS 414.705 (1)(k).

(6) Notwithstanding ORS 414.735, the Legislative Assembly shall adjust health services funded under ORS 414.705 (1) by increasing or reducing benefit packages or health services and, subject to ORS 414.709, by increasing or reducing the population of eligible persons.

SECTION 45. ORS 414.710 is amended to read:

414.710. The following services are available to persons eligible for services under ORS 414.025, 414.036, 414.042, 414.065 and 414.705 to 414.750 but such services are not subject to ORS 414.720:

(1) Nursing facilities and home- and community-based waivered services funded through the Department of Human Services;

(2) Medical assistance to eligible persons who receive assistance under ORS 411.706 or to children described in ORS 414.025 (2)(f), (i), (j), (k)**, (L)** and [*(m)*] **(n)**, 418.001 to 418.034, 418.189 to 418.970 and 657A.020 to 657A.460;

(3) Institutional, home- and community-based waivered services or community mental health program care for persons with mental retardation, developmental disabilities or severe mental illness and for the treatment of alcohol and drug dependent persons; and

(4) Services to children who are wards of the Department of Human Services by order of the juvenile court and services to children and families for health care or mental health care through the department.

SECTION 46. ORS 414.712 is amended to read:

414.712. The Department of Human Services shall provide medical assistance under ORS 414.705 to 414.750 to eligible persons who receive assistance under ORS 411.706 and to children described in ORS 414.025 (2)(f), (i), (j), (k)**, (L)** and [*(m)*] **(n)**, 418.001 to 418.034, 418.189 to 418.970 and 657A.020 to 657A.460 and those mental health and chemical dependency services recommended according to standards of medical assistance and according to the schedule of implementation established by the Legislative Assembly. In providing medical assistance services described in ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712, the Department of Human Services shall also provide the following:

(1) Ombudsman services for eligible persons who receive assistance under ORS 411.706. With the

concurrence of the Governor, the Director of Human Services shall appoint ombudsmen and may terminate an ombudsman. Ombudsmen are under the supervision and control of the director. An ombudsman shall serve as a patient's advocate whenever the patient or a physician or other medical personnel serving the patient is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider. Patients shall be informed of the availability of an ombudsman. Ombudsmen shall report to the Governor in writing at least once each quarter. A report shall include a summary of the services that the ombudsman provided during the quarter and the ombudsman's recommendations for improving ombudsman services and access to or quality of care provided to eligible persons by health care providers.

(2) Case management services in each health care provider organization for those eligible persons who receive assistance under ORS 411.706. Case managers shall be trained in and shall exhibit skills in communication with and sensitivity to the unique health care needs of people who receive assistance under ORS 411.706. Case managers shall be reasonably available to assist patients served by the organization with the coordination of the patient's health care services at the reasonable request of the patient or a physician or other medical personnel serving the patient. Patients shall be informed of the availability of case managers.

(3) A mechanism, established by rule, for soliciting consumer opinions and concerns regarding accessibility to and quality of the services of each health care provider.

(4) A choice of available medical plans and, within those plans, choice of a primary care provider.

(5) Due process procedures for any individual whose request for medical assistance coverage for any treatment or service is denied or is not acted upon with reasonable promptness. These procedures shall include an expedited process for cases in which a patient's medical needs require swift resolution of a dispute.

SECTION 47. ORS 414.736 is amended to read:

414.736. As used in this section and ORS 414.725, 414.737, 414.738, 414.739, 414.740, 414.741, 414.742, 414.743 and 414.744 **and section 9 of this 2009 Act**:

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

(2) "Fully capitated health plan" means an organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that the health services provided under the contract are reasonably accessible to enrollees.

(3) "Physician care organization" means an organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that the health services described in ORS 414.705 (1)(b), (c), (d), (e), (g) and (j) are reasonably accessible to enrollees. A physician care organization may also contract with the department on a prepaid capitated basis to provide the health services described in ORS 414.705 (1)(k) and (L).

(4) "Prepaid managed care health services organization" means a managed physical health, dental, mental health or chemical dependency organization that contracts with the Department of Human Services on a prepaid capitated basis under ORS 414.725. A prepaid managed care health services organization may be a dental care organization, fully capitated health plan, physician care organization, mental health organization or chemical dependency organization.

SECTION 48. ORS 731.036 is amended to read:

731.036. The Insurance Code does not apply to any of the following to the extent of the subject matter of the exemption:

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

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

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

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

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

(6) Cities, counties, school districts, community college districts, community college service districts or districts, as defined in ORS 198.010 and 198.180, that either individually or jointly insure for health insurance coverage, excluding disability insurance, their employees or retired employees, or their dependents, or students engaged in school activities, or combination of employees and dependents, with or without employee or student contributions, if all of the following conditions are met:

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

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

(B) In the case of an individual public body program other than a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals; and

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

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

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

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

(A) Written general information about services provided, access to services, charges and scheduling applicable to each enrollee's coverage;

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

(C) Other group health plan enrollee rights, disclosure or written procedure requirements established under ORS chapters 743 and 743A;

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

(A) Program contributions and reserves must be held in separate accounts and used for the exclusive benefit of the program;

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

(i) Known claims, paid and outstanding;

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

(iii) Claims handling expenses;

(iv) Unearned contributions; and

(v) A claims trend factor; and

(C) The program must maintain adequate reinsurance against the risk of economic loss in accordance with the provisions of ORS 742.065 unless the program has received written approval for an alternative arrangement for protection against economic loss from the Director of the Department of Consumer and Business Services;

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

(g) The individual or jointly self-insured program shall be subject to assessment in accordance with ORS 735.614 **and section 3 of this 2009 Act** and former enrollees shall be eligible for portability coverage in accordance with ORS 735.616;

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

(i) Each public body in a joint insurance program is liable only to its own employees and no others for benefits under the program in the event, and to the extent, that no further funds, including 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, which represents the actual cash value of the motor vehicle at the date of loss, and the amount owed under the agreement.

SECTION 49. 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 section 30 of this 2009 Act**.

SECTION 50. Notwithstanding section 9 (3), chapter 736, Oregon Laws 2003, moneys in the Hospital Quality Assurance Fund established under section 9, chapter 736, Oregon Laws 2003, that were received by the Department of Human Services prior to January 1, 2010, or if received on or after January 1, 2010, were derived from an assessment liability incurred prior to October 1, 2009, may be used by the department:

(1) During the biennium beginning July 1, 2009, to supplant, directly or indirectly, moneys appropriated to fund health services by the Seventy-fifth Legislative Assembly during the regular legislative session;

(2) To fund increased fee-for-service reimbursement rates for inpatient and outpatient hospital services provided prior to October 1, 2009; and

(3) To fund Medicaid cost settlements owed to hospitals due to the increase in fee-for-service rates under subsection (2) of this section.

SECTION 51. Sections 1 to 12, 15 and 29 of this 2009 Act, the amendments to ORS 731.292 and 731.840 by sections 13 and 25 of this 2009 Act and the amendments to sections 2, 5, 9, 10, 12, 13, 14 and 51, chapter 736, Oregon Laws 2003, by sections 17, 18, 19, 20, 21, 22, 23 and 24 of this 2009 Act become operative on October 1, 2009.

SECTION 52. 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.