B-Engrossed
House Bill 2194

Ordered by the Senate June 5
Including House Amendments dated February 17 and Senate Amendments dated June 5

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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.

Modifies definition of "medical insurance" for purposes of Oregon Medical Insurance Pool. Establishes majority of voting members of Oregon Medical Insurance Pool Board as quorum. Specifies types of insureds excluded from calculation of assessment. Prohibits coverage of person through Oregon Medical Insurance Pool if public health entity or health care provider pays premium for person and payment reduces financial loss of entity or provider even if reduction of loss is not sole purpose for payment. Modifies requirements for portability health benefit plan coverage under pool by removing requirement to reside in Oregon for 180 days.

A BILL FOR AN ACT

Relating to Oregon Medical Insurance Pool; amending ORS 735.605, 735.610, 735.614, 735.615 and 735.616.

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

SECTION 1. ORS 735.605 is amended to read:

735.605. As used in ORS 735.600 to 735.650:

(1) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to ORS 735.600 to 735.650.

(2) "Board" means the Oregon Medical Insurance Pool Board.

(3) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer.

(4) "Insurer" means:

(a) Any insurer as defined in ORS 731.106 or fraternal benefit society as defined in ORS 748.106 required to have a certificate of authority to transact health insurance business in this state, and any health care service contractor as defined in ORS 750.005[*, issuing medical insurance in this state on or after September 27, 1987*].

(b) Any reinsurer reinsuring medical insurance in this state [*on or after September 27, 1987*].

(c) To the extent consistent with federal law, any self-insurance arrangement covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state [*on or after September 27, 1987*].

(d) All self-insurance arrangements not covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state [*on or after September 27, 1987*].

(5) "Medical insurance" means [*any health insurance benefits payable on the basis of hospital,*

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.

surgical or medical expenses incurred and any health care service contractor subscriber contract. Medical insurance does not include accident only, disability income, hospital confinement indemnity, dental or credit insurance, coverage issued as a supplement to liability insurance, coverage issued as a supplement to Medicare, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.] **insurance of humans against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness or childbirth, or against expense incurred in prevention of sickness, in dental care or optometrical service, and every insurance appertaining thereto, including insurance against the risk of economic loss assumed under a less than fully insured employee health benefit plan. "Medical insurance" does not include workers' compensation coverages.**

(6) "Medicare" means coverage under Part A, Part B and Part D of Title XVIII of the Social Security Act, 42 U.S.C. [*1395*] **1395c** et seq., as amended.

(7) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to ORS 735.600 to 735.650.

(8) "Pool" means the Oregon Medical Insurance Pool as created by ORS 735.610.

(9) "Reinsurer" means any insurer as defined in ORS 731.106 from whom any person providing medical insurance to Oregon insureds procures insurance for itself in the insurer, with respect to all or part of the medical insurance risk of the person.

(10) "Self-insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide health care services or benefits to their employees or members in this state, either directly or indirectly through a trust or third party administrator, unless the health care services or benefits are provided by an insurance policy issued by an insurer other than a self-insurance arrangement.

SECTION 2. ORS 735.610 is amended to read:

735.610. (1) There is created in the Department of Consumer and Business Services the Oregon Medical Insurance Pool Board. The board shall establish the Oregon Medical Insurance Pool and otherwise carry out the responsibilities of the board under ORS 735.600 to 735.650.

(2) The board shall consist of nine individuals, eight of whom shall be appointed by the Director of the Department of Consumer and Business Services. The director [*of the Department of Consumer and Business Services*] or the director's designee shall be [*a*] **the ninth** member of the board. The chair of the board shall be elected from among the members of the board. The board shall at all times, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care service contractor, one representative of a health maintenance organization, one representative of reinsurers and two members of the general public who are not associated with the medical profession, a hospital or an insurer. **A majority of the voting members of the board constitutes a quorum for the transaction of business. An act by a majority of a quorum is an official act of the board.**

(3) The director may fill any vacancy on the board by appointment.

(4) The board shall have the general powers and authority granted under the laws of this state to insurance companies with a certificate of authority to transact health insurance and the specific authority to:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and pur-

poses of ORS 735.600 to 735.650 including the authority to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Recover any assessments for, on behalf of, or against insurers;

(c) Take such legal action as is necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, insurance producers' referral fees, claim reserves or formulas and perform any other actuarial function appropriate to the operation of the pool. Rates may not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(e) Issue policies of insurance in accordance with the requirements of ORS 735.600 to 735.650;

(f) Appoint from among insurers appropriate actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the board;

(g) Seek advances to effect the purposes of the pool; and

(h) Establish rules, conditions and procedures for reinsuring risks under ORS 735.600 to 735.650.

(5) Each member of the board is entitled to compensation and expenses as provided in ORS 292.495.

(6) The director [*of the Department of Consumer and Business Services*] shall adopt rules, as provided under ORS chapter 183, implementing policies recommended by the board for the purpose of carrying out ORS 735.600 to 735.650.

(7) In consultation with the board, the director shall employ such staff and consultants as may be necessary for the purpose of carrying out responsibilities under ORS 735.600 to 735.650.

SECTION 3. ORS 735.614 is amended to read:

735.614. (1) If the Oregon Medical Insurance Pool Board determines at any time that funds in the Oregon Medical Insurance Pool Account are or will become insufficient for payment of expenses of the pool in a timely manner, the board shall determine the amount of funds needed and shall impose and collect assessments against insurers, as provided in this section, in the amount of the funds determined to be needed.

(2) Each insurer's assessment shall be determined by multiplying the total amount to be assessed by a fraction, the numerator of which equals the number of Oregon insureds and certificate holders insured or reinsured by each insurer, and the denominator of which equals the total of all Oregon insureds and certificate holders insured or reinsured by all insurers, all determined as of March 31 each year.

(3) The board shall ensure that each insured and certificate holder is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains reinsurance for its insureds and certificate holders to include in its count of insureds and certificate holders all insureds and certificate holders whose coverage is reinsured in whole or part. The board shall allow an insurer who is a reinsurer to exclude from its number of insureds those that have been counted by the primary insurer or the primary reinsurer for the purpose of determining its assessment under this subsection.

(4) [*Each insurer shall pay its assessment as required by the board.*] **All insurers authorized to**

transact medical insurance in Oregon and that insure persons residing in Oregon are subject to the assessment under this section. Insureds under the following types of coverage, as defined by rule by the board, are excluded in the calculation of the assessment:

(a) Medicaid;

(b) State Children's Health Insurance Program;

(c) Medicare;

(d) Disability income insurance;

(e) Hospital only insurance;

(f) Dental insurance;

(g) Vision only insurance;

(h) Accident only insurance;

(i) Automobile insurance;

(j) Specific disease insurance;

(k) Medical supplemental plans;

(L) TRICARE;

(m) CHAMPUS;

(n) Prescription drug only plans;

(o) Long term care insurance; and

(p) Federal Employees Health Benefits Program.

(5) If assessments exceed the amounts actually needed, the excess shall be held and invested and, with the earnings and interest, used by the board to offset future net losses or to reduce pool premiums. For purposes of this subsection, "future net losses" includes reserves for claims incurred but not reported.

(6) Each insurer's proportion of participation in the pool shall be determined by the board based on annual statements and other reports deemed necessary by the board and filed by the insurer with the board. The board may use any reasonable method of estimating the number of insureds and certificate holders of an insurer if the specific number is unknown. With respect to insurers that are reinsurers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer.

(7) The board may abate or defer, in whole or in part, the assessment of an insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the insurer to fulfill the insurer's contractual obligations. In the event an assessment against an insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this section. The insurer receiving the abatement or deferment shall remain liable to the board for the deficiency for four years.

(8) The board shall abate or defer assessments authorized by this section if a court orders that assessments cannot be made applicable to reinsurers. However, if a court orders that assessments cannot be made applicable to reinsurers, the board may continue to assess insurers to the end of the biennium in which the determination is made.

(9) Subject to the approval of the Director of the Department of Consumer and Business Services, the board may develop a program for adjusting the assessment of an insurer in the individual health benefits market based on that insurer's contribution to reducing the enrollment in the Oregon Medical Insurance Pool. When developing the program, the board may consider, but is not limited to, the following factors:

(a) The insurer's level of participation;

(b) Level of health benefit plan coverage offered; and

(c) Assumption of risk in the individual health benefits market.

SECTION 4. ORS 735.615 is amended to read:

735.615. (1) Except as provided in subsection (3) of this section, a person who is a resident of this state, as defined by the Oregon Medical Insurance Pool Board, is eligible for medical pool coverage if:

(a) An insurer, or an insurance company with a certificate of authority in any other state, has made within a time frame established by the board an adverse underwriting decision, as defined in ORS 746.600 (1)(a)(A), (B) or (D), on individual medical insurance for health reasons while the person was a resident;

(b) The person has a history of any medical or health conditions on the list adopted by the board under subsection (2) of this section;

(c) The person is a spouse or dependent of a person described in paragraph (a) or (b) of this subsection; or

(d) The person is eligible for the credit for health insurance costs under section 35 of the federal Internal Revenue Code, as amended and in effect on December 31, 2004.

(2) The board may adopt a list of medical or health conditions for which a person is eligible for pool coverage without applying for individual medical insurance pursuant to this section.

(3) A person is not eligible for coverage under ORS 735.600 to 735.650 if:

(a) Except as provided in ORS 735.625 (3)(c), the person is eligible to receive health services as defined in ORS 414.705 that meet or exceed those adopted by the board or is eligible for Medicare;

(b) The person has terminated coverage in the pool within the last 12 months and the termination was for:

(A) A reason other than becoming eligible to receive health services as defined in ORS 414.705; or

(B) A reason that does not meet exception criteria established by the board;

(c) The person has exceeded the maximum lifetime benefit established by the board;

(d) The person is an inmate of or a patient in a public institution named in ORS 179.321;

(e) The person has, on the date of issue of coverage by the board, coverage under health insurance or a self-insurance arrangement that is substantially equivalent to coverage under ORS 735.625; or

(f) The person has the premiums paid or reimbursed by a public entity or a health care provider**,** [*for the sole purpose of*] reducing the financial loss or obligation of the payer.

(4) A person applying for coverage shall establish initial eligibility by providing evidence that the board requires.

(5)(a) Notwithstanding ORS 735.625 (4)(c) and subsection (3)(a) of this section, if a person becomes eligible for Medicare after being enrolled in the pool for a period of time as determined by the board by rule, that person may continue coverage within the pool as secondary coverage to Medicare.

(b) The board may adopt rules concerning the terms and conditions for the coverage provided under paragraph (a) of this subsection.

(6) The board may adopt rules to establish additional eligibility requirements for a person described in subsection (1)(d) of this section.

SECTION 5. ORS 735.616 is amended to read:

735.616. **(1) An applicant may qualify for portability health insurance coverage under the Oregon Medical Insurance Pool if:**

(a) An application for coverage is made not later than the 63rd day after the date of first eligibility; and

(b) The individual is an Oregon resident at the time of the application.

[*(1)*] **(2)** In addition to individuals otherwise qualified under ORS 735.615, the following individuals qualify for portability health insurance coverage under the Oregon Medical Insurance Pool [*if an application for coverage is made not later than the 63rd day after the date of first eligibility, as provided in subsection (2) of this section, and the individual is an Oregon resident at the time of such application*]:

(a) An individual who has left coverage that was [*continuously*] in effect for a [*period*] **minimum** of 180 **consecutive** days [*or more*] under one or more group health benefit plans, if[*:*]

[*(A)*] the terminated coverage was in a plan issued or established in a state other than Oregon; [*and*]

[*(B) The individual was an Oregon resident for at least 180 consecutive days immediately prior to the termination of coverage;*]

(b) An eligible individual, as defined in ORS 743.760, who has left coverage under a group health benefit plan or a portability health benefit plan and whose carrier cannot offer a portability plan under ORS 743.760 (6) because of:

(A) A change in residence of the eligible individual within Oregon;

(B) A change in the geographic area served by the group carrier; or

(C) The carrier's withdrawal from the group market in Oregon in accordance with ORS 743.737 and 743.754;

(c) An individual who has left coverage that was [*continuously*] in effect for [*a*] **an uninterrupted** period of 180 days or more under one or more Oregon group health benefit plans and the terminated coverage was provided by:

(A) An employee welfare benefit plan that is exempt from state regulation under the federal Employee Retirement Income Security Act of 1974, as amended;

(B) A multiple employer welfare arrangement subject to ORS 750.301 to 750.341; or

(C) A public body of this state in accordance with ORS 731.036; and

(d) On or after January 1, 1998, an individual who meets the eligibility requirements of 42 U.S.C. 300gg-41, as amended and in effect on January 1, 1998, and does not otherwise qualify to obtain portability coverage from an Oregon group carrier in accordance with ORS 743.760.

[*(2)*] **(3)** Eligibility for coverage pursuant to [*subsection (1)*] **subsections (1) and (2)** of this section is subject to the following provisions:

(a) An eligible individual does not include:

(A) An individual who remains eligible for the individual's prior group coverage or would remain eligible for prior group coverage in a plan under the federal Employee Retirement Income Security Act of 1974, as amended, were it not for action by the plan sponsor relating to the actual or expected health condition of the individual;

(B) An individual who is covered under another health benefit plan at the time that portability coverage would commence;

(C) An individual who is eligible to enroll in another health benefit plan offered by the employer, other than as a late enrollee, at the time that portability coverage would commence; or

(D) An individual who is eligible for the federal Medicare program.

(b) If an eligible individual has left group coverage issued by an insurance company, a health care service contractor or a health maintenance organization, the date of first eligibility is the day following the termination date of the group coverage, including any period of continuation coverage that was elected by the individual under federal law or under ORS 743.600 or 743.610.

(c) If an eligible individual has left group coverage issued by an entity other than an insurance company, a health care service contractor or a health maintenance organization, the date of first eligibility is the day following the termination date of the group coverage, including the full extent of continuation coverage available to the individual under federal law and ORS 743.600 and 743.610.

(d) If an individual is eligible for coverage pursuant to subsection [*(1)(b)*] **(2)(b)** of this section, the date of first eligibility is the day following the loss of the group or portability coverage.

[*(3)*] **(4)** Coverage under the Oregon Medical Insurance Pool pursuant to [*subsection (1)*] **subsections (1) and (2)** of this section shall be offered according to the following provisions:

(a) Coverage is subject to ORS 743.760 (2) and (8);

(b) Coverage may not be subject to a preexisting conditions provision, exclusion period, waiting period, residency period or other similar limitation on coverage; and

(c) The individual shall be required to pay a premium rate not more than the applicable portability risk rate determined by the Oregon Medical Insurance Pool Board pursuant to ORS 735.625.
