Enrolled
Senate Bill 862

Sponsored by Senator TELFER; Senators ATKINSON, BATES, FERRIOLI, GEORGE, GIROD, KRUSE, MONNES ANDERSON, MORRISETTE, MORSE, VERGER, WHITSETT, Representatives GARRETT, GREENLICK, KENNEMER, MAURER, STIEGLER, THOMPSON, WHISNANT

CHAPTER .....

AN ACT

Relating to reimbursement of health care costs; creating new provisions; amending ORS 731.036; and declaring an emergency.

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

SECTION 1. As used in sections 1 to 4 of this 2009 Act:

(1) "Community" means the area of geographically contiguous political subdivisions as determined by the Office for Oregon Health Policy and Research in collaboration with the board of directors of a community-based health care initiative.

(2) "Qualified employee" means an individual who:

(a) Is employed by a qualified employer;

(b) Resides or works within a community;

(c) Does not have health insurance; and

(d) Does not qualify for publicly funded health care.

(3) "Qualified employer" means an employer that:

(a) Employs 1 to 50 employees;

(b) Pays a median wage to its employees that is equal to or below an amount that is 300 percent of the federal poverty guidelines;

(c) For 12 months prior to enrollment in a community-based health care improvement program, or for the duration of the employer's operation if the employer has been in operation less than 12 months, has not provided to employees employer-based health insurance coverage for which the employer contributes at least 50 percent of the cost of premiums;

(d) Offers community-based health care services through a community-based health care improvement program to all qualified employees and their dependents regardless of health status;

(e) Agrees to participate in a community-based health care improvement program for at least 12 months; and

(f) Agrees to provide information that is deemed necessary by the community-based health care initiative to determine eligibility, assess dues and pay claims.

SECTION 2. (1) The Administrator of the Office for Oregon Health Policy and Research shall adopt rules for the approval of one community-based health care initiative per community that meets the requirements under subsection (2) of this section and of a community-based health care improvement program that meets the requirements under

subsection (3) of this section. The office may not approve community-based health care initiatives for more than three communities during the period beginning with the effective date of this 2009 Act and ending June 30, 2013.

(2) An approved community-based health care initiative shall:

(a) Be a nonprofit corporation governed by a board of directors that includes, but is not limited to, representatives of participating health care providers and qualified employers. At least 80 percent of the board members must be residents of the community.

(b) Contract with health care providers that offer health care services in the community to provide services to enrollees in the program.

(c) Recruit qualified employers to enroll in the program.

(d) Establish an operational structure for:

(A) Assisting employees of qualified employers or their dependents to enroll in state medical assistance programs if appropriate;

(B) Enrolling qualified employees and their dependents in the community-based health care improvement program;

(C) Billing and collecting dues from qualified employers and qualified employees; and

(D) Reimbursing participating health care providers for services to enrollees.

(e) Establish a set of health care services that are covered in the community-based health care improvement program, cost-sharing requirements and incentives to encourage the utilization of primary care, wellness and chronic disease management services.

(f) Maintain a liquid reserve account in an amount sufficient to pay all claims that have been incurred but not yet charged for a period of at least two months.

(g) Provide to each qualified employee enrolled in the program a clear and concise written statement that describes the community-based health care improvement program and that includes:

(A) The health care services that are covered;

(B) Any exclusions or limitations on coverage of health care services, including any requirements for prior authorization;

(C) Copayments, coinsurance, deductibles and any other cost-sharing requirements;

(D) A list of participating health care providers;

(E) The complaint process described in subsection (3)(b) of this section; and

(F) The conditions under which the program or coverage through the program may be terminated.

(h) Comply with the requirements of sections 3 and 4 of this 2009 Act.

(3) An approved community-based health care improvement program shall:

(a) Reimburse the cost of the set of health care services established by the initiative and provided in the community to qualified employers, qualified employees and their dependents.

(b) Include an enrollee complaint process that ensures the resolution of complaints within 45 days.

SECTION 3. (1) A community-based health care initiative may limit enrollment in a community-based health care improvement program. If enrollment is limited, the initiative must establish a waiting list.

(2) Except as provided in this section, an initiative may not restrict or deny enrollment in the program except for nonpayment of dues, fraud or misrepresentation.

(3) As a condition for enrolling a qualified employer and maintaining the employer's enrollment in the program, an initiative may require a minimum percentage of participation by qualified employees of an employer.

SECTION 4. A community-based health care initiative approved by the Administrator of the Office for Oregon Health Policy and Research must report to the Legislative Assembly no later than October 1 of each year. The report must contain at a minimum the following information:

(1) The financial status of the community-based health care improvement program, including the dues, the costs per enrollee per month, the total amount of claims paid, the total amount of dues collected and the administrative expenses;

(2) A description of the set of health care services covered by the program and an analysis of service utilization;

(3) The number of qualified employers, qualified employees and dependents enrolled;

(4) The number and scope of practice of participating health care providers;

(5) Recommendations for improving the program and establishing programs in other geographical regions of the state; and

(6) Any other information requested by the administrator or the Legislative Assembly.

SECTION 5. 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 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.

(10) A community-based health care initiative approved by the Administrator of the Office for Oregon Health Policy and Research under section 2 of this 2009 Act operating a community-based health care improvement program approved by the administrator.

SECTION 6. This 2009 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2009 Act takes effect on its passage.

Passed by Senate April 22, 2009

Repassed by Senate June 5, 2009

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Secretary of Senate

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President of Senate

Passed by House June 3, 2009

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Speaker of House

Received by Governor:

.....M.,....., 2009

Approved:

.....M.,....., 2009

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Governor

Filed in Office of Secretary of State:

.....M.,....., 2009

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Secretary of State