House Bill 3409

Sponsored by Representative KOTEK

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Authorizes payment for dental services under Family Health Insurance Assistance Program and under private health option of Health Care for All Oregon Children program. Authorizes Oregon Health Authority to provide packages of health services to specified groups of medical assistance recipients that are less comprehensive than health services on prioritized list of health services approved and funded by Legislative Assembly.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care; creating new provisions; amending ORS 414.025, 414.065, 414.428, 414.705, 414.706, 414.708, 414.709, 414.712, 414.720, 414.725, 414.735, 414.737, 414.738, 414.739, 414.740, 414.741, 414.826, 414.841, 414.842, 414.844 and 735.625; repealing ORS 414.707; and declaring an emergency.

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

SECTION 1. ORS 414.826 is amended to read:

414.826. (1) As used in this section:

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

(b) "Dental plan" has the meaning given that term in ORS 414.841.

[*(b)*] **(c)** "Health benefit plan" has the meaning given that term in ORS 414.841.

(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 414.856.

(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) To qualify for premium assistance under the private health option:

(a) A dental plan must provide coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions.

(b) Expenditures for the dental plan must qualify for federal financial participation.

[*(4)*] **(5)** The amount of premium assistance provided under this section shall be:

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.

(a) Equal to the full cost of the [*premium*] **premiums for a health benefit plan and a dental plan** 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 **or dental plan**.

[*(5)*] **(6)** 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 **or dental plan** through the private health option but may not receive premium assistance.

SECTION 2. ORS 414.841 is amended to read:

414.841. For purposes of ORS 414.841 to 414.864:

(1) "Carrier" has the meaning given that term in ORS 735.700.

(2) "Dental plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement only for the expenses of dental care.

[*(2)*] **(3)** "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) **Is** either**:**

(A) For health benefit plan coverage other than dental plans, a person who has been without health benefit plan coverage for a period of time established by the Office of Private Health Partnerships[,] or meets exception criteria established by the office; **or**

(B) For dental plan coverage, an individual under 19 years of age who is uninsured or underinsured with respect to dental plan coverage;

(d) Except as otherwise provided by the office, has family income [*less than*] **at or below** 200 percent of the federal poverty level; **and**

[*(e) Has investments and savings less than the limit established by the office; and*]

[*(f)*] **(e)** Meets other eligibility criteria established by the office.

[*(3)(a)*] **(4)(a)** "Family" means:

(A) A single individual;

(B) An adult and the adult's spouse;

(C) An adult and the adult's spouse, all unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult or the adult's spouse, and all dependent children of a dependent child; or

(D) An adult and the adult's unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult, and all dependent children of a dependent child.

(b) A family includes a dependent elderly relative or a dependent adult child with a disability who meets the criteria established by the office and who lives in the home of the adult described in paragraph (a) of this subsection.

[*(4)(a)*] **(5)(a)** "Health benefit plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement for hospital, medical and surgical expenses. "Health benefit plan" includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided

by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital indemnity only, [*dental only,*] vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.

[*(5)*] **(6)** "Income" means gross income in cash or kind available to the applicant or the applicant's family. Income does not include earned income of the applicant's children or income earned by a spouse if there is a legal separation.

[*(6) "Investment 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 office may establish that are available to the applicant or the applicant's family to contribute toward meeting the needs of an applicant or eligible individual.*]

(7) "Medicaid" means medical assistance provided under 42 U.S.C. section 1396a (section 1902 of the Social Security Act).

(8) "Resident" means an individual who meets the residency requirements established by rule by the office.

(9) "Subsidy" means payment or reimbursement to an eligible individual toward the purchase of a health benefit plan, and may include a net billing arrangement with carriers or a prospective or retrospective payment for health benefit plan premiums and eligible copayments or deductible expenses directly related to the eligible individual.

(10) "Third-party administrator" means any insurance company or other entity licensed under the Insurance Code to administer health [*insurance*] benefit [*programs*] **plans**.

SECTION 3. ORS 414.844 is amended to read:

414.844. (1) To enroll in the Family Health Insurance Assistance Program established in ORS 414.841 to 414.864, an applicant shall submit a written application to the Office of Private Health Partnerships or to the third-party administrator contracted by the office to administer the program pursuant to ORS 414.842 in the form and manner prescribed by the office. Except as provided in ORS 414.848, if the applicant qualifies as an eligible individual, the applicant shall either be enrolled in the program or placed on a waiting list for enrollment.

(2) After an eligible individual has enrolled in the program, the individual shall remain eligible for enrollment for the period of time established by the office.

(3) After an eligible individual has enrolled in the program, the office or third-party administrator shall issue subsidies in an amount determined pursuant to ORS 414.846 to either the eligible individual or to the carrier designated by the eligible individual, subject to the following restrictions:

(a) Subsidies may not be issued to an eligible individual unless all eligible children, if any, in the eligible individual's family are covered under a health benefit plan or Medicaid.

(b) Subsidies may not be used to subsidize premiums on a health benefit plan whose premiums are wholly paid by the eligible individual's employer without contribution from the employee.

(c) Such other restrictions as the office may adopt.

(4) The office may issue subsidies to an eligible individual in advance of a purchase of a health benefit plan.

(5) To remain eligible for a subsidy, an eligible individual must enroll in a group health benefit plan if a plan is available to the eligible individual through the individual's employment and the employer makes a monetary contribution toward the cost of the plan, unless the office implements specific cost or benefit structure criteria that make enrollment in an individual health insurance plan more advantageous for the eligible individual.

[*(6) Notwithstanding ORS 414.841 (4)(b), if an eligible individual is enrolled in a group health benefit plan available to the eligible individual through the individual's employment and the employer requires enrollment in both a health benefit plan and a dental plan, the individual is eligible for a subsidy for both the health benefit plan and the dental plan.*]

SECTION 4. ORS 414.025, as amended by section 1, chapter 73, Oregon Laws 2010, 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 and:

(A) Is in a foster family home or licensed child-caring agency or institution and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part; or

(B) Is 18 years of age or older, is one for whom federal financial participation is available under Title XIX or XXI of the federal Social Security Act and who met the criteria in subparagraph (A) of this paragraph immediately prior to the person's 18th birthday.

(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.

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

(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.

(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.

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

(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.

(p) Is an individual or member of a group who, subject to the rules of the department, 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.

(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.

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

(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*] **at or below** the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department by rule.

(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 ORS 414.231.

(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 Oregon Health Authority according to the standards established pursuant to ORS [*413.032*] **414.065**, including **premium assistance and** 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 5. ORS 414.065 is amended to read:

414.065. (1)(a) [*With respect to medical and remedial care and services to be provided in medical assistance during any period, and within the limits of funds available therefor, the Oregon Health Authority shall determine, subject to such revisions as it may make from time to time and*] With respect to the "health services" defined in ORS 414.705[*, subject to legislative funding in response to the report of the Health Services Commission and paragraph (b) of this subsection*] **that are approved and funded by the Legislative Assembly under ORS 414.720, the Oregon Health Authority shall determine**:

(A) The types and extent of medical and remedial care and services to be provided to each eligible group of recipients of medical assistance.

(B) Standards to be observed in the provision of medical and remedial care and services.

(C) The number of days of medical and remedial care and services toward the cost of which public assistance funds will be expended in the care of any person.

(D) Reasonable fees, charges and daily rates to which public assistance funds will be applied toward meeting the costs of providing medical and remedial care and services to an applicant or recipient.

(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(F) The amount and application of any copayment or other similar cost-sharing payment that the authority may require a recipient to pay toward the cost of medical and remedial care or services.

(b) [*Notwithstanding ORS 414.720 (8),*] The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

[*(2) The types and extent of medical and remedial care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the authority and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from public assistance funds available to providers of medical and remedial care and services in meeting the costs thereof.*]

[*(3)*] **(2)** Except for payments under a cost-sharing plan, payments made by the authority for medical assistance shall constitute payment in full for all medical and remedial care and services for which such payments of medical assistance were made.

[*(4)*] **(3)** Medical benefits, standards and limits established pursuant to subsection (1)(a)(A), (B) and (C) of this section for [*the eligible medically needy, except for persons receiving assistance under ORS 411.706,*] **persons described in ORS 414.706 (5)** may be less than [*but may not exceed*] medical benefits, standards and limits established for [*the eligible categorically needy, except that, in the case of a research and demonstration project entered into under ORS 411.135, medical benefits, standards and limits for the eligible medically needy may exceed those established for specific eligible groups of the categorically needy*] **persons described in ORS 414.706 (1), (2) and (3)**.

SECTION 6. ORS 414.705 is amended to read:

414.705. (1) As used in ORS 414.705 to 414.750, "health services" means at least so much of each of the following as are approved and funded by the Legislative Assembly **under ORS 414.720**:

(a) Services required by federal law to be included in the state's medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state's medical assistance program;

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

(2) Health services approved and funded under subsection (1) of this section are subject to the prioritized list of health services required in ORS 414.720.

SECTION 7. ORS 414.706 is amended to read:

414.706. [*The Legislative Assembly shall approve and fund health services to the following*] Persons **who are eligible for medical assistance include, but are not limited to**:

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

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

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

(4) Persons described in ORS 414.708; and

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

SECTION 8. ORS 414.708 is amended to read:

414.708. (1) A person is eligible to receive the health services described in ORS [*414.707 (2)*] **414.705 (1)(c), (f) and (g)** when the person is a resident of this state who:

(a) Is 65 years of age or older, or is blind or has a disability as those terms are defined in ORS 411.704;

(b) Has a gross annual income that does not exceed the standard established by the Oregon Health Policy Board; and

(c) Is not covered under any public or private prescription drug benefit program.

(2) A person receiving prescription drug services under [*ORS 414.707 (2)*] **subsection (1) of this section** shall pay up to a percentage of the Medicaid price of the prescription drug established by the authority by rule and the dispensing fee.

SECTION 9. ORS 414.709 is amended to read:

414.709. (1) Except as provided in subsection (2) of this section, if insufficient resources are available during a biennium, the population of eligible persons receiving health services may not be reduced below the population of eligible persons approved and funded in the legislatively adopted budget for the Oregon Health Authority for the biennium.

(2) The Oregon Health Authority may periodically limit enrollment **in medical assistance** of persons described in ORS **414.025 (2)(s) and** 414.708 **and participation in the program under ORS 414.231 (2)(b)** in order to stay within the legislatively adopted budget for the authority.

SECTION 10. ORS 414.712 is amended to read:

414.712. The Oregon Health Authority shall provide medical assistance [*under ORS 414.705 to 414.750*] to eligible persons who are determined eligible for medical assistance by the Department of Human Services according to ORS 411.706. The Oregon Health Authority shall also provide the following:

(1) Ombudsman services for eligible persons who receive assistance under ORS 411.706. With the concurrence of the Governor and the Oregon Health Policy Board, the Director of the Oregon Health Authority 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 and the Oregon Health Policy Board 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 11. ORS 414.720 is amended to read:

414.720. (1) The Health Services Commission shall conduct public hearings prior to making the report described in subsection (3) of this section. The commission shall solicit testimony and information from advocates representing seniors, persons with disabilities, mental health services consumers and low-income Oregonians, representatives of commercial carriers, representatives of small and large Oregon employers and providers of health care, including but not limited to physicians licensed to practice medicine, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

(2) The commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.

(3) The commission shall report to the Governor a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The list submitted by the commission pursuant to this subsection is not subject to alteration by any other state agency. The recommendation may include practice guidelines reviewed and adopted by the commission pursuant to subsection (4) of this section.

(4) In order to encourage effective and efficient medical evaluation and treatment, the commission:

(a) May include clinical practice guidelines in its prioritized list of services. The commission shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical practice guidelines developed by the commission.

(b) Shall consider both the clinical effectiveness and cost-effectiveness of health services in determining their relative importance using peer-reviewed medical literature as defined in ORS 743A.060.

(5) The commission shall make its report by July 1 of the year preceding each regular session

of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Representatives and the President of the Senate.

(6) Medical assistance provided pursuant to ORS 411.404, 414.065, 414.706 and 414.712 shall cover all health services on the list described in subsection (3) of this section to the level approved and funded by the Legislative Assembly.

[*(6)*] **(7)** The commission may alter the list during interim only under the following conditions:

(a) Technical changes due to errors and omissions; and

(b) Changes due to advancements in medical technology or new data regarding health outcomes.

[*(7)*] **(8)** If a service is deleted or added and no new funding is required, the [*commission*] **Oregon Health Authority** shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the [*commission*] **authority** must report to the Emergency Board to request the funding.

[*(8)*] **(9)** The [*report listing*] **list of health** services [*to be provided pursuant to ORS 411.404, 414.065, 414.705 to 414.725 and 414.735 to 414.750*] shall remain in effect from October 1 of the odd-numbered year through September 30 of the next odd-numbered year.

SECTION 12. ORS 414.725 is amended to read:

414.725. (1)(a) Pursuant to rules adopted by the Oregon Health Authority, the authority shall execute prepaid managed care health services contracts for health services **approved and** funded by the Legislative Assembly **under ORS 414.720**. **Subject to ORS 414.735 and 414.740,** the contract must require [*that all services are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract*] **coverage of all health services approved and funded by the Legislative Assembly under ORS 414.720**. The contracts are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235. [*Notwithstanding ORS 414.720 (8),*] The rules adopted by the authority shall establish timelines for executing the contracts described in this paragraph.

(b) [*It is the intent of ORS 414.705 to 414.750 that the state*] **The authority shall** use, to the greatest extent possible, prepaid managed care health services organizations to provide [*physical health, dental, mental health and chemical dependency services under ORS 414.705 to 414.750*] **health services**.

(c) The authority shall solicit qualified providers or plans to be reimbursed for providing the covered services. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private prepaid managed care health services organization. The authority may not discriminate against any contractors that offer services within their providers' lawful scopes of practice.

(d) The authority shall establish annual financial reporting requirements for prepaid managed care health services organizations. The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each prepaid managed care health services organization and that includes information on the three highest executive salary and benefit packages of each prepaid managed care health services organization.

(e) The authority shall require compliance with the provisions of paragraph (d) of this subsection as a condition of entering into a contract with a prepaid managed care health services organization.

(f)(A) The authority shall adopt rules and procedures to ensure that a rural health clinic that provides a health service to an enrollee of a prepaid managed care health services organization receives total aggregate payments from the organization, other payers on the claim and the authority

that are no less than the amount the rural health clinic would receive in the authority's fee-for-service payment system. The authority shall issue a payment to the rural health clinic in accordance with this subsection within 45 days of receipt by the authority of a completed billing form.

(B) "Rural health clinic," as used in this paragraph, shall be defined by the authority by rule and shall conform, as far as practicable or applicable in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

(2) The authority may institute a fee-for-service case management system or a fee-for-service payment system for the [*same physical health, dental, mental health or chemical dependency*] **health** services provided under [*the health services contracts for persons eligible for health services under ORS 414.705 to 414.750*] **medical assistance** in [*designated*] areas of the state in which a prepaid managed care health services organization is not able to assign an enrollee to a person [*or entity*] that is primarily responsible for coordinating the [*physical health, dental, mental health or chemical dependency*] **enrollee's health** services [*provided to the enrollee*]. In addition, the authority may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the authority for health services [*provided pursuant to ORS 414.705 to 414.750*] may not exceed the total dollars appropriated for health services [*under ORS 414.705 to 414.750*].

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting to provide **health** services [*under ORS 414.705 to 414.750*] shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) A prepaid managed care health services organization shall provide information on contacting available providers to an enrollee in writing within 30 days of assignment to the health services organization.

(7) Each prepaid managed care health services organization shall provide upon the request of an enrollee or prospective enrollee annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to enrollees.

(8) A prepaid managed care health services organization may not limit enrollment in a designated area based on the zip code of an enrollee or prospective enrollee.

SECTION 13. ORS 414.735 is amended to read:

414.735. (1) If insufficient resources are available during a contract period:

(a) The population of eligible persons determined by law shall not be reduced.

(b) The reimbursement rate for providers and plans established under the contractual agreement shall not be reduced.

(2) In the circumstances described in subsection (1) of this section, reimbursement shall be adjusted by reducing the health services for the eligible population by eliminating services in the order of priority recommended by the Health Services Commission, starting with the least important and

progressing toward the most important.

(3) The Oregon Health Policy Board shall obtain the approval of the Legislative Assembly, or the Emergency Board if the Legislative Assembly is not in session, before instituting the reductions. In addition, providers contracting to provide health services [*under ORS 414.705 to 414.750*] must be notified at least two weeks prior to any legislative consideration of such reductions. Any reductions made under this section shall take effect no sooner than 60 days following final legislative action approving the reductions.

(4) This section does not apply to reductions made by the Legislative Assembly in a legislatively adopted or approved budget.

SECTION 14. ORS 414.737 is amended to read:

414.737. (1) Except as provided in subsections (2) and (3) of this section, a person who is eligible for or receiving [*physical health, dental, mental health or chemical dependency services under ORS 414.705 to 414.750*] **medical assistance** must be enrolled in the prepaid managed care health services organizations to receive the health services for which the person is eligible.

(2) Subsection (1) of this section does not apply to:

(a) A person who**, because of the person's immigration status,** is [*a noncitizen and who is*] eligible only for labor and delivery services and emergency treatment services;

(b) A person who is an American Indian and Alaskan Native beneficiary; and

(c) A person whom the Oregon Health Authority may by rule exempt from the mandatory enrollment requirement of subsection (1) of this section, including but not limited to:

(A) A person who is also eligible for Medicare;

(B) A woman in her third trimester of pregnancy at the time of enrollment;

(C) A person under 19 years of age who has been placed in adoptive or foster care out of state;

(D) A person under 18 years of age who is medically fragile and who has special health care needs; and

(E) A person with major medical coverage.

(3) Subsection (1) of this section does not apply to a person who resides in a designated area in which a prepaid managed care health services organization providing [*physical health, dental, mental health or chemical dependency*] **health** services is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the [*physical health, dental, mental health or chemical dependency*] **health** services provided to the enrollee.

(4) 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 15. ORS 414.737, as amended by section 8, chapter 751, Oregon Laws 2007, and section 331, chapter 595, Oregon Laws 2009, is amended to read:

414.737. (1) Except as provided in subsections (2) and (3) of this section, a person who is eligible for or receiving [*physical health, dental, mental health or chemical dependency services under ORS 414.705 to 414.750*] **medical assistance** must be enrolled in the prepaid managed care health services organizations to receive the health services for which the person is eligible.

(2) Subsection (1) of this section does not apply to:

(a) A person who**, because of the person's immigration status,** is [*a noncitizen and who is*]

eligible only for labor and delivery services and emergency treatment services;

(b) A person who is an American Indian and Alaskan Native beneficiary; and

(c) A person whom the Oregon Health Authority may by rule exempt from the mandatory enrollment requirement of subsection (1) of this section, including but not limited to:

(A) A person who is also eligible for Medicare;

(B) A woman in her third trimester of pregnancy at the time of enrollment;

(C) A person under 19 years of age who has been placed in adoptive or foster care out of state;

(D) A person under 18 years of age who is medically fragile and who has special health care needs; **and**

[*(E) A person receiving services under the Medically Involved Home-Care Program created by ORS 417.345 (1); and*]

[*(F)*] **(E)** A person with major medical coverage.

(3) Subsection (1) of this section does not apply to a person who resides in a designated area in which a prepaid managed care health services organization providing [*physical health, dental, mental health or chemical dependency*] **health** services is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the [*physical health, dental, mental health or chemical dependency*] **health** services provided to the enrollee.

(4) 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 16. ORS 414.738 is amended to read:

414.738. (1) If the Oregon Health Authority has not been able to contract with the fully capitated health plan or plans in a designated area, the authority may contract with a physician care organization in the designated area.

(2) The Office for Oregon Health Policy and Research shall develop criteria that the authority shall consider when determining the circumstances under which the authority may contract with a physician care organization. The criteria developed by the office shall include but not be limited to the following:

(a) The physician care organization must be able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health services provided to the enrollee;

(b) The contract with a physician care organization does not threaten the financial viability of other fully capitated health plans in the designated area; and

(c) The contract with a physician care organization must be consistent with the legislative intent of using prepaid managed care health services organizations to provide **health** services [*under ORS 414.705 to 414.750*].

SECTION 17. ORS 414.739 is amended to read:

414.739. (1) A fully capitated health plan may apply to the Oregon Health Authority to contract with the authority as a physician care organization rather than as a fully capitated health plan to provide **health** services [*under ORS 414.705 to 414.750*].

(2) The Office for Oregon Health Policy and Research shall develop the criteria that the authority must use to determine the circumstances under which the authority may accept an application by a fully capitated health plan to contract as a physician care organization. The criteria

developed by the office shall include but not be limited to the following:

(a) The fully capitated health plan must show documented losses due to hospital risk and must show due diligence in managing those risks; and

(b) Contracting as a physician care organization is financially viable for the fully capitated health plan.

SECTION 18. ORS 414.740 is amended to read:

414.740. (1) Notwithstanding ORS 414.738 (1), the Oregon Health Authority shall contract under ORS 414.725 with a prepaid group practice health plan that serves at least 200,000 members in this state and that has been issued a certificate of authority by the Department of Consumer and Business Services as a health care service contractor to provide health services as described in ORS 414.705 (1)(b), (c), (d), (e), (g) and (j). A health plan may also contract with the authority on a prepaid capitated basis to provide the health services described in ORS 414.705 (1)(k) and (L). The authority may accept financial contributions from any public or private entity to help implement and administer the contract. The authority shall seek federal matching funds for any financial contributions received under this section.

(2) In a designated area, in addition to the contract described in subsection (1) of this section, the authority shall contract with prepaid managed care health services organizations to provide health services [*under ORS 414.705 to 414.750*].

SECTION 19. ORS 414.741 is amended to read:

414.741. (1) The Health Services Commission shall retain an actuary to determine the benchmark for setting per capita rates necessary to reimburse prepaid managed care health services organizations and fee-for-service providers for the cost of providing health services [*under ORS 414.705 to 414.750*].

(2) The actuary retained by the commission shall use the following information to determine the benchmark for setting per capita rates:

(a) For hospital services, the most recently available Medicare cost reports for Oregon hospitals;

(b) For services of physicians licensed under ORS chapter 677 and other health professionals using procedure codes, the Medicare Resource Based Relative Value system conversion rates for Oregon;

(c) For prescription drugs, the most recent payment methodologies in the fee-for-service payment system for the medical assistance program;

(d) For durable medical equipment and supplies, 80 percent of the Medicare allowable charge for purchases and rentals;

(e) For dental services, the most recent payment rates obtained from dental care organization encounter data; and

(f) For all other services not listed in paragraphs (a) to (e) of this subsection:

(A) The Medicare maximum allowable charge, if available; or

(B) The most recent payment rates obtained from the data available under subsection (3) of this section.

(3) The actuary shall use the most current encounter data and the most current fee-for-service data that is available, reasonable trends for utilization and cost changes to the midpoint of the next biennium, appropriate differences in utilization and cost based on geography, state and federal mandates and other factors that, in the professional judgment of the actuary, are relevant to the fair and reasonable estimation of costs. The Department of Human Services shall provide the actuary with the data and information in the possession of the department or contractors of the department

reasonably necessary to develop a benchmark for setting per capita rates.

(4) The commission shall report the benchmark per capita rates developed under this section to the Director of the Oregon Department of Administrative Services, the Director of the Oregon Health Authority and the Legislative Fiscal Officer no later than August 1 of every even-numbered year.

(5) The Oregon Health Authority shall retain an actuary to determine:

(a) Per capita rates for health services that the authority shall use to develop the authority's proposed biennial budget; and

(b) Capitation rates to reimburse physician care organizations for the cost of providing health services [*under ORS 414.705 to 414.750*] using the same methodologies used to develop capitation rates for fully capitated health plans. The rates may not advantage or disadvantage fully capitated health plans for similar services.

(6) The Oregon Health Authority shall submit to the Legislative Assembly no later than February 1 of every odd-numbered year a report comparing the per capita rates for health services on which the proposed budget of the authority is based with the rates developed by the actuary retained by the Health Services Commission. If the rates differ, the authority shall disclose, by provider categories described in subsection (2) of this section, the amount of and reason for each variance.

SECTION 20. ORS 414.428 is amended to read:

414.428. (1) An individual described in ORS 414.025 (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 414.707 (1)*] **all the health services approved and funded by the Legislative Assembly** if:

(a) The Oregon Health Authority receives 100 percent federal medical assistance percentage for payments made by the authority for the health [*care*] services [*provided as part of the benefit package described in ORS 414.707 (1)*]; or

(b) The authority 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 21. ORS 414.842 is amended to read:

414.842. (1) There is established the Family Health Insurance Assistance Program in the Office of Private Health Partnerships. The purpose of the program is to remove economic barriers to health insurance coverage for residents of the State of Oregon with family income [*less than*] **at or below** 200 percent of the federal poverty level[*, and investment and savings less than the limit established by the office,*] while encouraging individual responsibility, promoting health benefit plan coverage of children, building on the private sector health benefit plan system and encouraging employer and employee participation in employer-sponsored health benefit plan coverage.

(2) The Office of Private Health Partnerships shall be responsible for the implementation and operation of the Family Health Insurance Assistance Program. The Administrator of the Office for Oregon Health Policy and Research, in consultation with the Oregon Health Policy Board, shall

make recommendations to the Office of Private Health Partnerships regarding program policy, including but not limited to eligibility requirements, assistance levels, benefit criteria and carrier participation.

(3) The Office of Private Health Partnerships may contract with one or more third-party administrators to administer one or more components of the Family Health Insurance Assistance Program. Duties of a third-party administrator may include but are not limited to:

(a) Eligibility determination;

(b) Data collection;

(c) Assistance payments;

(d) Financial tracking and reporting; and

(e) Such other services as the office may deem necessary for the administration of the program.

(4) If the office decides to enter into a contract with a third-party administrator pursuant to subsection (3) of this section, the office shall engage in competitive bidding. The office shall evaluate bids according to criteria established by the office, including but not limited to:

(a) The bidder's proven ability to administer a program of the size of the Family Health Insurance Assistance Program;

(b) The efficiency of the bidder's payment procedures;

(c) The estimate provided of the total charges necessary to administer the program; and

(d) The bidder's ability to operate the program in a cost-effective manner.

SECTION 22. ORS 735.625 is amended to read:

735.625. (1) Except as provided in subsection (3)(c) of this section, the Oregon Medical Insurance Pool Board shall offer major medical expense coverage to every eligible person.

(2) The coverage to be issued by the board, its schedule of benefits, exclusions and other limitations, shall be established through rules adopted by the board, taking into consideration the advice and recommendations of the pool members. In the absence of such rules, the pool shall adopt by rule the minimum benefits prescribed by section 6 (Alternative 1) of the Model Health Insurance Pooling Mechanism Act of the National Association of Insurance Commissioners (1984).

(3)(a) In establishing portability coverage under the pool, the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations that the board determines are equivalent to the portability health benefit plans established under ORS 743.760.

(b) In establishing medical insurance coverage under the pool, the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations that the board determines are equivalent to those found in the commercial group or employer-based medical insurance market.

(c) The board may provide a separate Medicare supplement policy for individuals under the age of 65 who are receiving Medicare disability benefits. The board shall adopt rules to establish benefits, deductibles, coinsurance, exclusions and limitations, premiums and eligibility requirements for the Medicare supplement policy.

(d) In establishing medical insurance coverage for persons eligible for coverage under ORS 735.615 (1)(d), the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations to create benefit plans that

qualify the person 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.

(4)(a) Premiums charged for coverages issued by the board may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age and geographical location may apply for individual risks.

(c) The board shall determine the applicable medical and portability risk rates either by calculating the average rate charged by insurers offering coverages in the state comparable to the pool coverage or by using reasonable actuarial techniques. The risk rates shall reflect anticipated experience and expenses for such coverage. Rates for pool coverage may not be more than 125 percent of rates established as applicable for medically eligible individuals or for persons eligible for pool coverage under ORS 735.615 (1)(d), or 100 percent of rates established as applicable for portability eligible individuals.

(d) The board shall annually determine adjusted benefits and premiums. The adjustments shall be in keeping with the purposes of ORS 735.600 to 735.650, subject to a limitation of keeping pool losses under one percent of the total of all medical insurance premiums, subscriber contract charges and 110 percent of all benefits paid by member self-insurance arrangements. The board may determine the total number of persons that may be enrolled for coverage at any time and may permit and prohibit enrollment in order to maintain the number authorized. Nothing in this paragraph authorizes the board to prohibit enrollment for any reason other than to control the number of persons in the pool.

(5)(a) The board may apply:

(A) A waiting period of not more than 90 days during which the person has no available coverage; or

(B) Except as provided in paragraph (c) of this subsection, a preexisting conditions provision of not more than six months from the effective date of coverage under the pool.

(b) In determining whether a preexisting conditions provision applies to an eligible enrollee, except as provided in this subsection, the board shall credit the time the eligible enrollee was covered under a previous health benefit plan if the previous health benefit plan was continuous to a date not more than 63 days prior to the effective date of the new coverage under the Oregon Medical Insurance Pool, exclusive of any applicable waiting period. The Oregon Medical Insurance Pool Board need not credit the time for previous coverage to which the insured or dependent is otherwise entitled under this subsection with respect to benefits and services covered in the pool coverage that were not covered in the previous coverage.

(c) The board may adopt rules applying a preexisting conditions provision to a person who is eligible for coverage under ORS 735.615 (1)(d).

(d) For purposes of this subsection, a "preexisting conditions provision" means a provision that excludes coverage for services, charges or expenses incurred during a specified period not to exceed six months following the insured's effective date of coverage, for a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the insured's effective date of coverage.

(6)(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or self-insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by

any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except [*the Medicaid portion of the medical assistance program offering a level of health services described in ORS 414.707*] **medical assistance**.

(b) The board shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(7) Except as provided in ORS 735.616, no mandated benefit statutes apply to pool coverage under ORS 735.600 to 735.650.

(8) Pool coverage may be furnished through a health care service contractor or such alternative delivery system as will contain costs while maintaining quality of care.

SECTION 23. The amendments to ORS 414.826, 414.841, 414.842 and 414.844 by sections 1 to 3 of this 2011 Act become operative January 1, 2012.

SECTION 24. ORS 414.707 is repealed.

SECTION 25. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.