House Bill 3510

Sponsored by Representative DEMBROW; Representatives BAILEY, FREDERICK, GREENLICK, NOLAN, TOMEI, Senators DINGFELDER, SHIELDS

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.**

Establishes Affordable Health Care for All Oregon Plan, operated by Oregon Health Authority according to policies established by Affordable Health Care for All Oregon Board. Provides comprehensive health care coverage to all individuals residing or working in Oregon. Supplants coverage by private insurers for health services covered by plan. Requires public employees to be covered by plan. Creates Affordable Health Care for All Oregon Fund. Continuously appropriates moneys in fund to authority. Provides for implementation of plan on January 2, 2014.

Requires board to establish policies and approve administrative rules for certificate of need process. Expands certificate of need to include both new and existing health care facilities.

Repeals Oregon Health Insurance Exchange, Oregon Medical Insurance Pool Board, Oregon Medical Insurance Pool, Office of Private Health Partnerships, Family Health Insurance Assistance Program and private health option under Health Care for All Oregon Children program on January 2, 2014.

Appropriates moneys from General Fund to authority for purposes of plan.

A BILL FOR AN ACT

Relating to statewide coverage of health care; creating new provisions; amending ORS 65.957, 192.519, 243.105, 243.125, 243.135, 243.215, 243.860, 243.864, 243.866, 243.868, 291.055, 413.011, 413.017, 413.032, 413.033, 413.201, 414.041, 414.231, 430.315, 433.443, 442.015, 442.315, 442.325, 705.145, 731.036, 734.790, 743.402, 743.730, 743.748, 743.766, 743.767, 743.769, 743A.001, 744.704, 746.600, 748.603 and 750.055 and section 1, chapter 867, Oregon Laws 2009; repealing ORS 413.064, 413.075, 414.825, 414.826, 414.828, 414.831, 414.839, 414.841, 414.842, 414.844, 414.846, 414.848, 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866, 414.868, 414.870, 414.872, 735.600, 735.605, 735.610, 735.612, 735.614, 735.615, 735.616, 735.620, 735.625, 735.630, 735.635, 735.640, 735.645, 735.650, 735.700, 735.701, 735.702, 735.703, 735.705, 735.707, 735.709, 735.710, 735.711, 735.712, 735.714 and 746.222 and section 17, chapter 595, Oregon Laws 2009, and sections 1, 2, 3, 4 and 5, chapter 47, Oregon Laws 2010; and appropriating money.

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

ESTABLISHMENT OF THE AFFORDABLE HEALTH CARE FOR ALL OREGON PLAN

SECTION 1. (1) The Affordable Health Care for All Oregon Plan is established to ensure access to quality, patient-centered and affordable health care for all individuals living or working in Oregon, to improve the public's health and to control the cost of health care for the benefit of individuals, families, businesses and society.

(2) The plan shall pay the costs of medically necessary health services in the following categories within the scope prescribed by the Affordable Health Care for All Oregon Board, excluding health services provided for cosmetic purposes only:

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) Primary and preventive care, including health education;

(b) Specialty care;

(c) Inpatient and outpatient hospital care;

(d) Emergency care;

(e) Home health care;

(f) Prescription drugs according to a formulary;

(g) Durable medical equipment;

(h) Mental health services;

(i) Substance abuse treatment;

(j) Dental services;

(k) Chiropractic services;

(L) Basic vision and vision correction;

(m) Diagnostic imaging, laboratory services and other diagnostic and evaluation services;

(n) Inpatient and outpatient rehabilitative services;

(o) Emergency transportation;

(p) Translation of verbal and written language;

(q) Hospice care;

(r) Podiatry;

(s) Acupuncture; and

(t) Dialysis.

(3) A person and the immediate family members of a person are eligible to enroll in the plan if the person:

(a) Resides in this state; or

(b) Is employed in this state.

(4) Except as provided in section 2 of this 2011 Act, no copayments, deductibles or other form of cost sharing may be imposed on enrollees under the plan.

(5) Enrollees in the plan may choose any health care provider licensed or certified in this state or in another state for services within the scope of the provider's license or certification.

(6) Within the scope of services covered within each category, enrollees and their health care providers shall determine what treatment is medically necessary.

(7) A health care provider may not discriminate against any enrollee on the basis of race, religion, nationality, sex, sexual orientation, age, wealth or any basis prohibited by the civil rights laws of this state.

(8) A health care provider must accept payment from the plan as payment in full and may not bill a patient for an amount exceeding the payment made by the plan.

(9) A payment under the plan to a health care facility for operational expenses may not be used by the facility to pay for or to replace other funds used to pay for capital expenditures.

(10) Administrative costs of the plan may not exceed:

(a) Twelve percent of total costs of the plan during the first two years of plan operation.

(b) Eight percent of total costs of the plan during the third and fourth years of plan operation.

(c) Five percent of total costs of the plan during the fifth and subsequent years of plan operation.

(11) Loss of eligibility due to no longer meeting the criteria in subsection (3) of this section shall be considered a qualifying event, and the Oregon Health Authority shall be considered to be a plan sponsor of a group health plan for purposes of continuation coverage required by 29 U.S.C. 1161.

SECTION 2. No later than January 1, 2015, the Affordable Health Care for All Oregon Board established under section 5 of this 2011 Act shall develop and submit to the Legislative Assembly a recommendation for the coverage of long term care services by the Affordable Health Care for All Oregon Plan. The recommendation may allow for the imposition on enrollees of copayments, deductibles or other forms of cost sharing.

SECTION 3. An insurer with a certificate of authority to transact insurance issued by the Department of Consumer and Business Services may not offer in this state a policy or certificate of health insurance that covers services provided under the Affordable Health Care for All Oregon Plan.

SECTION 4. Actions taken by insurers may not be considered to be the transaction of insurance for purposes of the Insurance Code if the actions are:

(1) Taken in accordance with the requirements adopted pursuant to sections 1, 7 and 10 of this 2011 Act; and

(2) Approved by the Oregon Health Authority or the Affordable Health Care for All Oregon Board.

AFFORDABLE HEALTH CARE FOR ALL OREGON BOARD

SECTION 5. (1) There is established the Affordable Health Care for All Oregon Board, consisting of nine members appointed by the Governor, subject to confirmation by the Senate in the manner prescribed by ORS 171.562 and 171.565, who shall include:

(a) A licensed or certified health care provider;

(b) A public health official;

(c) A representative of organized labor; and

(d) A representative of business who is not employed by a health care provider, pharmaceutical company, health insurer or medical supply company.

(2) The term of office of each member is four years and begins on January 2. A new term begins on the expiration of the previous term. A member is eligible for reappointment. The Governor shall appoint a person to fill any vacancy, subject to confirmation by the Senate. Any appointment to a vacant position shall become immediately effective for the unexpired term.

(3) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(4) A majority of the members of the board constitutes a quorum for the transaction of business.

(5) The board shall meet at least once every three months at a place, day and hour determined by the chairperson. The board may also meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

(6) The board shall adopt rules of ethics and definitions of conflicts of interest for determining the circumstances under which members of the board must recuse themselves

from voting.

(7) The Oregon Health Authority shall provide staff support for the board.

(8) A member of the board is entitled to compensation and expenses as provided in ORS 292.495 for participation in board and subcommittee meetings.

(9) In accordance with applicable provisions of ORS chapter 183, the board may adopt rules necessary for the administration of the laws that the board is charged with administering.

SECTION 6. Notwithstanding section 5 of this 2011 Act, of the members first appointed to the Affordable Health Care for All Oregon Board:

(1) Three shall serve for terms ending December 31, 2013.

(2) Three shall serve for terms ending December 31, 2014.

(3) Three shall serve for terms ending December 31, 2015.

SECTION 7. The Affordable Health Care for All Oregon Board is responsible for the development, implementation, management and oversight of the Affordable Health Care for All Oregon Plan established in section 1 of this 2011 Act, including but not limited to all of the following duties:

(1) Determining and regularly updating the scope of coverage within each category described in section 1 (2) of this 2011 Act in consultation with enrollees and guided by evidence-based practices that integrate clinical expertise, patient values and current research.

(2) Approving the package of benefits covered in the plan.

(3) Overseeing management of the Affordable Health Care for All Oregon Fund.

(4) Determining policies and adopting rules to guide the operation of the plan, including but not limited to:

(a) Establishing eligibility standards for enrollment, including standards for presumptive eligibility determinations;

(b) Ensuring meaningful access by enrollees to quality health services included in the benefit package;

(c) Ensuring that the plan covers health services that:

(A) Are evidence-based and cost-effective in promoting health; and

(B) Emphasize disease prevention and health promotion;

(d) Developing quality of care indicators;

(e) Establishing policies regarding conflicts of interest for health care providers and health care facilities;

(f) Regularly soliciting input from the public, including individuals with specialized health service needs, through district advisory committees and other means;

(g) Hiring an executive director for the plan who serves at the pleasure of the board;

(h) Approving contracts for services provided by health care facilities;

(i) Approving contracts with pharmaceutical and durable medical equipment providers;

(j) Seeking all waivers, exemptions and agreements from federal, state and local government sources that are necessary to provide funding for the plan; and

(k) Ensuring that implementation of the plan affects all individuals equitably, regardless of health status, age, disability, employment status or income.

(5) Partnering with public health agencies to improve the public's health.

(6) Reporting, at least annually, to the Legislative Assembly on the performance of the

plan and recommending needed legislative changes.

(7) Implementing a program to provide retraining for workers dislocated by the creation of the plan.

(8) Establishing an appeal process, in accordance with ORS chapter 183, and an ombudsman office for both health care providers and enrollees to appeal adverse determinations by the board or the Oregon Health Authority and to resolve complaints.

(9) Submitting to the Legislative Assembly an estimate of the funding needed to operate the plan.

(10) Ensuring an annual audit is conducted of the revenue and expenses of the plan.

(11) Establishing procedures and terms for payments to in-state and out-of-state health care providers for covered services provided under the plan.

(12) Establishing policies for the certificate of need process under ORS 442.315.

SECTION 8. (1) The Affordable Health Care for All Oregon Board shall establish a program to operate during the first four years of operation of the Affordable Health Care for All Oregon Plan to pay for or to reimburse the costs of retraining for workers who are displaced by the implementation of the plan.

(2) The board shall apply for federal and private gifts and grants available to operate the program.

(3) A worker is eligible for no more than 24 months of retraining under this section.

SECTION 9. (1) The Affordable Health Care for All Oregon Board shall appoint for each congressional district a district advisory committee consisting of residents of the district, to solicit input, receive complaints, conduct public hearings, facilitate accountability or assist the board in any manner deemed appropriate by the board to meet the health service needs of residents of the congressional district.

(2) The Oregon Health Authority shall provide staff support to each district advisory committee.

DUTIES OF THE OREGON HEALTH AUTHORITY IN ADMINISTERING THE AFFORDABLE HEALTH CARE FOR ALL OREGON PLAN

SECTION 10. The Oregon Health Authority, under the direction, policies and oversight of the Affordable Health Care for All Oregon Board, shall:

(1) Adopt rules approved by the board necessary for carrying out the authority's duties under this section;

(2) Propose goals, objectives and standards to achieve quality and affordable health care accessible to all Oregonians and propose major policy changes to the board;

(3) Establish systems to monitor and evaluate access, quality and cost of health services provided to Oregonians;

(4) Direct research to improve health and health services;

(5) Identify legislation needed to improve health services covered under the Affordable Health Care for All Oregon Plan;

(6) Establish collaborative partnerships with public health agencies;

(7) Make recommendations to the board for ensuring equity in the delivery of culturally sensitive health care to all Oregon populations;

(8) Develop a biennial budget for board and legislative approval;

(9) Administer the legislatively approved budget for the plan;

(10) Report periodically to the board, the Governor and the Legislative Assembly on the progress of implementing the plan and on the financial status of the plan;

(11) Arrange for appropriate and timely support for the board to carry out the board's functions;

(12) Ensure prompt payment for all plan expenditures;

(13) Contract with health care providers, insurers and health care service contractors to provide or administer health services under the plan and contract for actuarial, legal, technical or other professional services as needed;

(14) Negotiate favorable prices in contracts entered into with health care providers, insurers and health care service contractors;

(15) Direct ongoing, effective communication and outreach to ensure Oregonians are well-informed about the plan;

(16) Process applications and determine eligibility for individuals seeking to enroll or to renew enrollment in the plan;

(17) Operate the program developed by the board under section 8 of this 2011 Act to provide retraining for workers dislocated by the creation of the plan;

(18) Provide prompt responses to suggestions, complaints and grievances submitted by health care providers and enrollees under the process established by the board in section 7 (8) of this 2011 Act; and

(19) Perform other functions delegated by the board to the authority.

CERTIFICATES OF NEED

SECTION 11. ORS 442.315 is amended to read:

442.315. (1) Any [*new hospital or new skilled nursing or intermediate care service or*] **health care** facility not excluded pursuant to ORS 441.065 shall obtain a certificate of need from the Oregon Health Authority prior to an offering or development.

(2) The authority shall adopt rules**, in compliance with policies developed and subject to approval by the Affordable Health Care for All Oregon Board,** specifying criteria and procedures for making decisions as to the need for the new services or facilities.

(3)(a) An applicant for a certificate of need shall apply to the authority on forms provided for this purpose by authority rule.

(b) An applicant shall pay a fee prescribed as provided in this section. Subject to the approval of the [*Oregon Department of Administrative Services*] **Affordable Health Care for All Oregon Board**, the authority shall prescribe application fees, based on the complexity and scope of the proposed project.

(4) The authority shall be the decision-making authority for the purpose of certificates of need.

(5)(a) An applicant or any affected person who is dissatisfied with the proposed decision of the authority is entitled to an informal hearing in the course of review and before a final decision is rendered.

(b) Following a final decision being rendered by the authority, an applicant or any affected person may request a reconsideration hearing pursuant to ORS chapter 183.

(c) In any proceeding brought by an affected person or an applicant challenging an authority decision under this subsection, the authority shall follow procedures consistent with the provisions

of ORS chapter 183 relating to a contested case.

(6) Once a certificate of need has been issued, it may not be revoked or rescinded unless it was acquired by fraud or deceit. However, if the authority finds that a person is offering or developing a project that is not within the scope of the certificate of need, the authority may limit the project as specified in the issued certificate of need or reconsider the application. A certificate of need is not transferable.

(7) Nothing in this section applies to any [*hospital, skilled nursing or intermediate care service or*] **health care** facility that seeks to replace equipment with equipment of similar basic technological function or an upgrade that improves the quality or cost-effectiveness of the service provided. Any person acquiring such replacement or upgrade shall file a letter of intent for the project in accordance with the rules of the authority if the price of the replacement equipment or upgrade exceeds $1 million.

(8) [*Except as required in subsection (1) of this section for a new hospital or new skilled nursing or intermediate care service or facility not operating as a Medicare swing bed program, nothing in*] This section [*requires*] **does not require** a rural hospital as defined in ORS 442.470 (5)(a)(A) and (B) to obtain a certificate of need.

(9) Nothing in this section applies to basic health services, but basic health services do not include:

(a) Magnetic resonance imaging scanners;

(b) Positron emission tomography scanners;

(c) Cardiac catheterization equipment;

(d) Megavoltage radiation therapy equipment;

(e) Extracorporeal shock wave lithotriptors;

(f) Neonatal intensive care;

(g) Burn care;

(h) Trauma care;

(i) Inpatient psychiatric services;

(j) Inpatient chemical dependency services;

(k) Inpatient rehabilitation services;

(L) Open heart surgery; or

(m) Organ transplant services.

(10) In addition to any other remedy provided by law, whenever it appears that any person is engaged in, or is about to engage in, any acts that constitute a violation of this section, or any rule or order issued by the authority under this section, the authority may institute proceedings in the circuit courts to enforce obedience to such statute, rule or order by injunction or by other processes, mandatory or otherwise.

[*(11) As used in this section, "basic health services" means health services offered in or through a hospital licensed under ORS chapter 441, except skilled nursing or intermediate care nursing facilities or services and those services specified in subsection (9) of this section.*]

SECTION 12. ORS 442.325 is amended to read:

442.325. (1) A certificate of need shall be required for the development or establishment of a health care facility of any [*new*] health maintenance organization.

(2) Any activity of a health maintenance organization which does not involve the direct delivery of health services, as distinguished from arrangements for indirect delivery of health services through contracts with providers, shall be exempt from certificate of need review.

(3) [*Nothing in ORS 244.050, 431.250,*] **ORS** 441.015 to 441.087[,] **and** 442.015 to 442.420 [*and 442.450 applies*] **do not apply** to any decision of a health maintenance organization involving its organizational structure, its arrangements for financing health services, the terms of its contracts with enrolled beneficiaries or its scope of benefits.

(4) With the exception of certificate of need requirements, when applicable, the licensing and regulation of health maintenance organizations shall be controlled by ORS 750.005 to 750.095 and statutes incorporated by reference therein.

(5) It is the policy of ORS [*244.050, 431.250,*] 441.015 to 441.087[,] **and** 442.015 to 442.420 [*and 442.450*] to encourage the growth of health maintenance organizations as an alternative delivery system and to provide the facilities for the provision of quality health care to the present and future members who may enroll within their defined service area.

(6)(a) It is also the policy of ORS [*244.050, 431.250,*] 441.015 to 441.087[,] **and** 442.015 to 442.420 [*and 442.450*] to consider the special needs and circumstances of health maintenance organizations. Such needs and circumstances include the needs of and costs to members and projected members of the health maintenance organization in obtaining health services and the potential for a reduction in the use of inpatient care in the community through an extension of preventive health services and the provision of more systematic and comprehensive health services. The consideration of a new health service proposed by a health maintenance organization shall also address the availability and cost of obtaining the proposed new health service from the existing providers in the area that are not health maintenance organizations.

(b) The Oregon Health Authority shall issue a certificate of need for beds, services or equipment to meet the needs or reasonably anticipated needs of members of health maintenance organizations when beds, services or equipment are not available from nonplan providers.

PUBLIC EMPLOYEE PARTICIPATION IN THE AFFORDABLE HEALTH CARE FOR ALL OREGON PLAN

(Public Employees' Benefit Board)

SECTION 13. ORS 243.105 is amended to read:

243.105. As used in ORS 243.105 to 243.285, unless the context requires otherwise:

(1) "Benefit plan" includes, but is not limited to:

(a) Contracts for insurance or other benefits, including medical, dental, vision, life, disability and other health care recognized by state law, and related services and supplies;

(b) Comparable benefits for employees who rely on spiritual means of healing; [*and*]

(c) Self-insurance programs managed by the Public Employees' Benefit Board**; and**

(d) The Affordable Health Care for All Oregon Plan.

(2) "Board" means the Public Employees' Benefit Board.

(3) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation, or a board-approved guarantor of benefit plan coverage and compensation.

(4)(a) "Eligible employee" means an officer or employee of a state agency who elects to participate in one of the group benefit plans described in ORS 243.135. The term includes state officers

and employees in the exempt, unclassified and classified service, and state officers and employees, whether or not retired, who:

(A) Are receiving a service retirement allowance, a disability retirement allowance or a pension under the Public Employees Retirement System or are receiving a service retirement allowance, a disability retirement allowance or a pension under any other retirement or disability benefit plan or system offered by the State of Oregon for its officers and employees;

(B) Are eligible to receive a service retirement allowance under the Public Employees Retirement System and have reached earliest retirement age under ORS chapter 238;

(C) Are eligible to receive a pension under ORS 238A.100 to 238A.245, and have reached earliest retirement age as described in ORS 238A.165; or

(D) Are eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by the State of Oregon and have attained earliest retirement age under the plan or system.

(b) "Eligible employee" does not include individuals:

(A) Engaged as independent contractors;

(B) Whose periods of employment in emergency work are on an intermittent or irregular basis;

(C) Who are employed on less than half-time basis unless the individuals are employed in positions classified as job-sharing positions, unless the individuals are defined as eligible under rules of the board;

(D) Appointed under ORS 240.309;

(E) Provided sheltered employment or make-work by the state in an employment or industries program maintained for the benefit of such individuals; or

(F) Provided student health care services in conjunction with their enrollment as students at the state institutions of higher education.

(5) "Family member" means an eligible employee's spouse and any unmarried child or stepchild within age limits and other conditions imposed by the board with regard to unmarried children or stepchildren.

(6) "Payroll disbursing officer" means the officer or official authorized to disburse moneys in payment of salaries and wages of employees of a state agency.

(7) "Premium" means the monthly or other periodic charge for a benefit plan.

(8) "State agency" means every state officer, board, commission, department or other activity of state government.

SECTION 14. ORS 243.125 is amended to read:

243.125. (1) The Public Employees' Benefit Board shall prescribe rules for the conduct of its business. The board shall study all matters connected with the providing of adequate benefit plan coverage for eligible state employees on the best basis possible with relation both to the welfare of the employees and to the state. The board shall design benefits, devise specifications, analyze carrier responses to advertisements for bids and decide on the award of contracts. Contracts shall be signed by the chairperson on behalf of the board.

(2) In carrying out its duties under subsection (1) of this section, the goal of the board shall be to provide a high quality plan of health and other benefits for state employees at a cost affordable to both the employer and the employees.

(3) Subject to ORS chapter 183, the board may make rules not inconsistent with ORS 243.105 to 243.285 and 292.051 to determine the terms and conditions of eligible employee participation and coverage.

(4) The board shall prepare specifications, invite bids and do acts necessary to award contracts for health benefit plan and dental benefit plan coverage of eligible employees in accordance with the criteria set forth in ORS 243.135 [*(1)*] **(2)**.

(5) The board may retain consultants, brokers or other advisory personnel when necessary and, subject to the State Personnel Relations Law, shall employ such personnel as are required to perform the functions of the board.

SECTION 15. ORS 243.135, as amended by section 1, chapter 49, Oregon Laws 2010, is amended to read:

243.135. **(1) Any person who is eligible to participate in a health benefit plan available to state employees pursuant to ORS 243.105 to 243.285 shall enroll in the Affordable Health Care for All Oregon Plan.**

[*(1)*] **(2)** [*Notwithstanding any other benefit plan contracted for and offered by the Public Employees' Benefit Board*] **If the Public Employees' Benefit Board contracts for health benefit plans to supplement coverage provided in the Affordable Health Care for All Oregon Plan**, the board shall contract for a **supplemental** health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees and the state. In considering whether to enter into a contract for a **supplemental** plan, the board shall place emphasis on:

(a) Employee choice among high quality plans;

(b) A competitive marketplace;

(c) Plan performance and information;

(d) Employer flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

(g) Plan benefits as part of total employee compensation; and

(h) The improvement of employee health.

[*(2)*] **(3)** The board may approve more than one carrier for each type of **supplemental** plan contracted for and offered but the number of carriers shall be held to a number consistent with adequate service to eligible employees and their family members.

[*(3)*] **(4)** Where appropriate for a contracted and offered **supplemental** health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members.

[*(4)*] **(5)** Payroll deductions for such costs as are not payable by the state may be made upon receipt of a signed authorization from the employee indicating an election to participate in the **supplemental** plan or plans selected and the deduction of a certain sum from the employee's pay.

[*(5)*] **(6)** In developing any **supplemental** health benefit plan, the board may provide an option of additional coverage for eligible employees and their family members at an additional cost or premium.

[*(6)*] **(7)** Transfer of enrollment from one plan to another shall be open to all eligible employees and their family members under rules adopted by the board. Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable physician-patient relations between a particular panel of physicians and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

[*(7)*] **(8)** The board shall evaluate a **supplemental** benefit plan that serves a limited geographic

region of this state according to the criteria described in subsection [*(1)*] **(2)** of this section.

SECTION 16. ORS 243.215 is amended to read:

243.215. Any eligible employee unable to participate in one or more of the plans described in ORS 243.135 [*(1)*] solely because the employee is assigned to perform duties outside the state may be eligible to receive the monthly state contribution, less administrative expenses, as payment of all or part of the cost of a health benefit plan of choice, subject to the approval of the Public Employees' Benefit Board and such rules as the board may adopt.

(Oregon Educators Benefit Board)

SECTION 17. ORS 243.860 is amended to read:

243.860. As used in ORS 243.860 to 243.886, unless the context requires otherwise:

(1) "Benefit plan" includes but is not limited to:

(a) Contracts for insurance or other benefits, including medical, dental, vision, life, disability and other health care recognized by state law, and related services and supplies;

(b) Self-insurance programs managed by the Oregon Educators Benefit Board; [*and*]

(c) Comparable benefits for employees who rely on spiritual means of healing**; and**

(d) The Affordable Health Care for All Oregon Plan.

(2) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation, or a board-approved provider or guarantor of benefit plan coverage and compensation.

(3) "District" means a common school district, a union high school district, an education service district, as defined in ORS 334.003, or a community college district, as defined in ORS 341.005.

(4)(a) "Eligible employee" includes:

(A) An officer or employee of a district who elects to participate in one of the benefit plans described in ORS 243.864 to 243.874; and

(B) An officer or employee of a district, whether or not retired, who:

(i) Is receiving a service retirement allowance, a disability retirement allowance or a pension under the Public Employees Retirement System or is receiving a service retirement allowance, a disability retirement allowance or a pension under any other retirement or disability benefit plan or system offered by the district for its officers and employees;

(ii) Is eligible to receive a service retirement allowance under the Public Employees Retirement System and has reached earliest service retirement age under ORS chapter 238;

(iii) Is eligible to receive a pension under ORS 238A.100 to 238A.245 and has reached earliest retirement age as described in ORS 238A.165; or

(iv) Is eligible to receive a service retirement allowance or pension under any other retirement benefit plan or system offered by the district and has attained earliest retirement age under the plan or system.

(b) Except as provided in paragraph (a)(B) of this subsection, "eligible employee" does not include an individual:

(A) Engaged as an independent contractor;

(B) Whose periods of employment in emergency work are on an intermittent or irregular basis; or

(C) Who is employed on less than a half-time basis unless the individual is employed in a position classified as a job-sharing position or unless the individual is defined as eligible under rules of the Oregon Educators Benefit Board or under a collective bargaining agreement.

(5) "Family member" means an eligible employee's spouse or domestic partner and any unmarried child or stepchild of an eligible employee within age limits and other conditions imposed by the Oregon Educators Benefit Board with regard to unmarried children or stepchildren.

(6) "Payroll disbursing officer" means the officer or official authorized to disburse moneys in payment of salaries and wages of officers and employees of a district.

(7) "Premium" means the monthly or other periodic charge, including administrative fees of the Oregon Educators Benefit Board, for a benefit plan.

SECTION 18. ORS 243.864 is amended to read:

243.864. (1) The Oregon Educators Benefit Board:

(a) Shall adopt rules for the conduct of its business; and

(b) May adopt rules not inconsistent with ORS 243.860 to 243.886 to determine the terms and conditions of eligible employee participation in and coverage under benefit plans.

(2) The board shall study all matters connected with the provision of adequate benefit plan coverage for eligible employees on the best basis possible with regard to the welfare of the employees and affordability for the districts. The board shall design benefits, prepare specifications, analyze carrier responses to advertisements for bids and award contracts. Contracts shall be signed by the chairperson on behalf of the board.

(3) In carrying out its duties under subsections (1) and (2) of this section, the goal of the board is to provide high-quality health, dental and other benefit plans for eligible employees at a cost affordable to the districts, the employees and the taxpayers of Oregon.

(4) The board shall prepare specifications, invite bids and take actions necessary to award contracts for health and dental benefit plan coverage of eligible employees in accordance with the criteria set forth in ORS 243.866 [*(1)*] **(2)**. The Public Contracting Code does not apply to contracts for benefit plans provided under ORS 243.860 to 243.886. The board may not exclude from competition to contract for a benefit plan an Oregon carrier solely because the carrier does not serve all counties in Oregon.

(5) The board may retain consultants, brokers or other advisory personnel when necessary and shall employ such personnel as are required to perform the functions of the board.

SECTION 19. ORS 243.866, as amended by section 2, chapter 49, Oregon Laws 2010, is amended to read:

243.866. **(1) Any person who is eligible to participate in a health benefit plan under ORS 243.860 to 243.886 shall enroll in the Affordable Health Care for All Oregon Plan.**

[*(1)*] **(2) If** the Oregon Educators Benefit Board **contracts for health benefit plans to supplement coverage provided in the Affordable Health Care for All Oregon Plan, the board** shall contract for **supplemental** benefit plans best designed to meet the needs and provide for the welfare of eligible employees and the districts. In considering whether to enter into a contract for a **supplemental** benefit plan, the board shall place emphasis on:

(a) Employee choice among high-quality plans;

(b) Encouragement of a competitive marketplace;

(c) Plan performance and information;

(d) District flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

(g) Plan benefits as part of total employee compensation; and

(h) Improvement of employee health.

[*(2)*] **(3)** The board may approve more than one carrier for each type of **supplemental** benefit plan offered, but the board shall limit the number of carriers to a number consistent with adequate service to eligible employees and family members.

[*(3)*] **(4)** When appropriate, the board shall provide options under which an eligible employee may arrange coverage for family members under a **supplemental** benefit plan.

[*(4)*] **(5)** A district shall provide that payroll deductions for **supplemental** benefit plan costs that are not payable by the district may be made upon receipt of a signed authorization from the employee indicating an election to participate in the **supplemental** benefit plan or plans selected and allowing the deduction of those costs from the employee's pay.

[*(5)*] **(6)** In developing any **supplemental** benefit plan, the board may provide an option of additional coverage for eligible employees and family members at an additional premium.

[*(6)*] **(7)** The board shall adopt rules providing that transfer of enrollment from one benefit plan to another is open to all eligible employees and family members. Because of the special problems that may arise involving acceptable physician-patient relations between a particular panel of physicians and a particular eligible employee or family member under a comprehensive group practice benefit plan, the board shall provide a procedure under which any eligible employee may apply at any time to substitute another benefit plan for participation in a comprehensive group practice benefit plan.

[*(7) An eligible employee who is retired is not required to participate in a health benefit plan offered under this section in order to obtain dental benefit plan coverage. The board shall establish by rule standards of eligibility for retired employees to participate in a dental benefit plan.*]

(8) The board shall evaluate a **supplemental** benefit plan that serves a limited geographic region of this state according to the criteria described in subsection [*(1)*] **(2)** of this section.

SECTION 20. ORS 243.868 is amended to read:

243.868. (1) [*In addition to contracting for health and dental benefit plans,*] The Oregon Educators Benefit Board may contract with carriers to provide [*other*] benefit plans including, but not limited to, insurance or other benefits based on life, supplemental medical, supplemental dental, supplemental vision, accidental death or disability insurance plans.

(2) The premium for each eligible employee for coverage under a benefit plan [*other than a health or dental benefit plan*] described in subsection (1) of this section shall be the total cost per month of the coverage afforded the employee under the plan for which the employee exercises an option, including the cost of enrollment of the eligible employee and administrative expenses for the plan.

(3) The board may withdraw approval of any additional benefit plan in the same manner as it withdraws approval of a health or dental benefit plan as described and authorized by ORS 243.878.

(4) If the board does not contract for a benefit plan described in subsection (1) of this section, a district may contract for the benefit plan on behalf of any district employees. The administrative expenses of the plan shall be paid in accordance with the district's negotiated agreement with the employees. Benefit plans entered into by a district are subject to approval by the board before they become operative. The board may withdraw approval of any such benefit plan in the same manner as it withdraws approval of a benefit plan under ORS 243.878.

AFFORDABLE HEALTH CARE FOR ALL OREGON FUND

SECTION 21. (1) The Affordable Health Care for All Oregon Fund is established in the State Treasury, separate and distinct from the General Fund, consisting of moneys received under ORS 243.185 and 243.882 and sections 8 and 23 of this 2011 Act, moneys appropriated by the Legislative Assembly and moneys received from federal, state, county and local governments and private sources to pay for health care services covered by the Affordable Health Care for All Oregon Plan. Moneys in the Affordable Health Care for All Oregon Fund are continuously appropriated to the Oregon Health Authority to administer the Affordable Health Care for All Oregon Plan and to carry out sections 1, 5, 7, 8, 9, 10, 23 and 24 of this 2011 Act and ORS 442.315 and 442.325.

(2) The Affordable Health Care for All Oregon Reserve Account is established in the Affordable Health Care for All Oregon Fund and consists of moneys transferred from the fund to the reserve account under section 22 of this 2011 Act. Notwithstanding ORS 293.190, any moneys remaining in the account at the end of a biennium that were appropriated from the General Fund do not revert to the General Fund.

SECTION 22. (1) Whenever the amount of moneys in the Affordable Health Care for All Oregon Fund exceeds the amount obligated for the remainder of the biennium, the Oregon Health Authority shall transfer the excess amount to the Affordable Health Care for All Oregon Reserve Account. Moneys in the reserve account may be transferred to the fund as necessary to carry out the provisions specified in section 21 of this 2011 Act.

(2) The Affordable Health Care for All Oregon Board shall establish a maximum cap for the amount of moneys to be maintained in the reserve account.

SECTION 23. (1) The Affordable Health Care for All Oregon Plan shall be the primary payer of reimbursement for health services provided through the plan, including but not limited to compensable medical expenses covered by workers' compensation insurance.

(2) The Oregon Health Authority is subrogated to the rights of any person that has a claim against an insurer, tortfeasor, employer, third party administrator, pension manager, public or private corporation, government entity or any other person that may be liable for the cost of health services paid for by the Affordable Health Care for All Oregon Plan.

(3) The authority may enter into an agreement with any person for the prepayment of claims anticipated to arise under subsection (2) of this section during a biennium. At the end of the biennium, the authority shall appropriately charge or refund to the payer the difference between the amount prepaid and the amount due.

(4) All moneys recovered pursuant to this section shall be deposited in the Affordable Health Care for All Oregon Fund established in section 21 of this 2011 Act.

FINANCING OF THE AFFORDABLE HEALTH CARE FOR ALL OREGON PLAN

SECTION 24. (1) The Affordable Health Care for All Oregon Board shall develop recommendations for dedicated funding mechanisms to finance the Affordable Health Care for All Oregon Plan. In lieu of premiums, copayments, coinsurance and deductibles, the plan must be funded by a system of dedicated, progressive taxes that are based on the payer's ability to pay. The board shall consider an employer payroll tax, a graduated personal income tax,

a transaction tax on stocks and bonds, other taxes on unearned income, a progressive surtax on higher incomes and a progressive tax on gross business receipts divided by full-time equivalent employment. Funding sources must be assessed based on the capacity of the source to generate sufficient revenue to fund the plan and maintain an adequate reserve. The burden of the assessments must be distributed according to ability to pay.

(2) The board shall report its recommendations to the 2013 regular session of the Legislative Assembly as specified in ORS 171.010.

ABOLISHMENT OF OREGON MEDICAL INSURANCE POOL PROGRAM

SECTION 25. (1) The Oregon Medical Insurance Pool Board is abolished. On the operative date of this section, the tenure of office of the members of the Oregon Medical Insurance Pool Board ceases.

(2) All moneys remaining in the Oregon Medical Insurance Pool Account and the Temporary High Risk Pool Program Fund on the operative date of this section are transferred for deposit in the Affordable Health Care for All Oregon Fund.

SECTION 26. The abolishment of the Oregon Medical Insurance Pool Board by section 25 of this 2011 Act does not affect any action, proceeding or prosecution involving or with respect to the duties, functions and powers of the board begun before and pending at the time of the abolishment, except that the Oregon Health Authority is substituted for the board in the action, proceeding or prosecution.

SECTION 27. (1) Nothing in sections 25 and 26 of this 2011 Act, the amendments to statutes by sections 38 to 67 of this 2011 Act or the repeal of statutes by sections 69 and 70 of this 2011 Act relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions and powers of the Oregon Medical Insurance Pool Board that accrues before the operative date of section 25 of this 2011 Act. The Oregon Health Authority may undertake the collection or enforcement of any such liability, duty or obligation.

(2) The rights and obligations of the board legally incurred under contracts, leases and business transactions executed, entered into or begun before the operative date of section 25 of this 2011 Act are transferred to the authority. For the purpose of succession to these rights and obligations, the Oregon Health Authority is a continuation of the board and not a new authority.

SECTION 28. The rules of the Oregon Medical Insurance Pool Board in effect on the operative date of section 25 of this 2011 Act continue in effect until superseded or repealed by rules of the Oregon Health Authority. References in rules of the board to the board or an officer or employee of the board are considered to be references to the authority or an officer or employee of the authority.

SECTION 29. Whenever, in any uncodified law or resolution of the Legislative Assembly or in any rule, document, record or proceeding authorized by the Legislative Assembly, reference is made to the Oregon Medical Insurance Pool Board or an officer or employee of the board, the reference is considered to be a reference to the Oregon Health Authority or an officer or employee of the authority.

SECTION 30. For the purpose of harmonizing and clarifying statutory law, the Legislative Counsel may substitute for words designating the "Oregon Medical Insurance Pool Board"

or its officers, wherever they occur in statutory law, words designating the "Oregon Health Authority" or its officers.

SECTION 31. For the purpose of harmonizing and clarifying statutory law, the Legislative Counsel may substitute for words designating the "Oregon Medical Insurance Pool Account" or "Temporary High Risk Pool Program Fund," wherever they occur in statutory law, words designating the "Affordable Health Care for All Oregon Fund."

ABOLISHMENT OF OFFICE OF PRIVATE HEALTH PARTNERSHIPS

SECTION 32. The Office of Private Health Partnerships is abolished. On the operative date of this section, the tenure of the Administrator of the Office of Private Health Partnerships ceases.

SECTION 33. The abolishment of the Office of Private Health Partnerships by section 32 of this 2011 Act does not affect any action, proceeding or prosecution involving or with respect to the duties, functions and powers of the office begun before and pending at the time of the abolishment, except that the Oregon Health Authority is substituted for the Office of Private Health Partnerships in the action, proceeding or prosecution.

SECTION 34. (1) Nothing in sections 32 and 33 of this 2011 Act, the amendments to statutes by sections 38 to 67 of this 2011 Act or the repeal of statutes by sections 69 and 70 of this 2011 Act relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions and powers of the Office of Private Health Partnerships that accrues before the operative date of section 32 of this 2011 Act. The Oregon Health Authority may undertake the collection or enforcement of any such liability, duty or obligation.

(2) The rights and obligations of the Office of Private Health Partnerships legally incurred under contracts, leases and business transactions executed, entered into or begun before the operative date of section 32 of this 2011 Act are transferred to the authority. For the purpose of succession to these rights and obligations, the Oregon Health Authority is a continuation of the office and not a new authority.

SECTION 35. The rules of the Office of Private Health Partnerships in effect on the operative date of section 32 of this 2011 Act continue in effect until superseded or repealed by rules of the Oregon Health Authority. References in rules of the office to the office or an administrator or employee of the office are considered to be references to the authority or an administrator or employee of the authority.

SECTION 36. Whenever, in any uncodified law or resolution of the Legislative Assembly or in any rule, document, record or proceeding authorized by the Legislative Assembly, reference is made to the Office of Private Health Partnerships or to an administrator or employee of the office, the reference is considered to be a reference to the Oregon Health Authority or an administrator or employee of the authority.

SECTION 37. For the purpose of harmonizing and clarifying statutory law, the Legislative Counsel may substitute for words designating the "Office of Private Health Partnerships" or its administrator, wherever they occur in statutory law, words designating the "Oregon Health Authority" or its director.

CONFORMING AMENDMENTS

SECTION 38. ORS 65.957 is amended to read:

65.957. (1) This chapter applies to all domestic corporations in existence on October 3, 1989, that were incorporated under any general statute of this state providing for incorporation of nonprofit corporations if power to amend or repeal the statute under which the corporation was incorporated was reserved.

(2) Without limitation as to any other corporations that may be outside the scope of subsection (1) of this section, this chapter does not apply to the following:

(a) The Oregon State Bar and the Oregon State Bar Professional Liability Fund created under ORS 9.005 to 9.755;

(b) The State Accident Insurance Fund Corporation created under ORS chapter 656;

(c) The Oregon Insurance Guaranty Association and the Oregon Life and Health Insurance Guaranty Association created under ORS chapter 734; and

(d) The Oregon FAIR Plan Association [*and the Oregon Medical Insurance Pool*] created under ORS chapter 735.

SECTION 39. ORS 192.519 is amended to read:

192.519. As used in ORS 192.518 to 192.529:

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) "Covered entity" means:

(a) A state health plan;

(b) A health insurer;

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

(d) A health care clearinghouse.

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

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

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

(b) Case management and care coordination;

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

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating de-identified information; and

(j) Fundraising.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

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

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

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

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

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

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

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

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

(w) A pharmacy as defined in ORS 689.005;

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

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

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

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

(b) Relates to:

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

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

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

(7) "Health insurer" means[*:*]

[*(a)*] an insurer as defined in ORS 731.106 who offers:

[*(A)*] **(a)** A health benefit plan as defined in ORS 743.730;

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

[*(C)*] **(c)** A student health insurance policy;

[*(D)*] **(d)** A Medicare supplemental policy; or

[*(E)*] **(e)** A dental only policy.

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

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

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

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

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

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

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

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

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

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

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

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

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

(d) A person described in ORS 192.526.

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

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

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

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

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

(12) "State health plan" means:

(a) Medical assistance as defined in ORS 414.025;

(b) The Health Care for All Oregon Children program;

[*(c) The Family Health Insurance Assistance Program established in ORS 414.841 to 414.864; or*]

(c) The Affordable Health Care for All Oregon Plan established by section 1 of this 2011 Act; or

(d) Any medical assistance or premium assistance program operated by the Oregon Health Authority.

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

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

(b) Consultations and referrals between health care providers.

SECTION 40. ORS 291.055 is amended to read:

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

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

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

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

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

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

(2) This section does not apply to:

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

(b) Taxes or other payments made or collected from employers for unemployment insurance re-

quired by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

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

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

[*(C)*] **(B)** Copayments and premiums paid to the Oregon medical assistance program.

[*(D)*] **(C)** Assessments paid to the Department of Consumer and Business Services under ORS 743.951 and 743.961.

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

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

(f) Any intergovernmental charges.

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

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

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

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

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

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

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

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

(o) Convenience fees as defined in ORS 182.126 and established by the Oregon Department of Administrative Services under ORS 182.132 (3) and recommended by the Electronic Government Portal Advisory Board.

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

(A) The reason for the fee decrease; and

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

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

SECTION 41. ORS 413.011 is amended to read:

413.011. (1) The duties of the Oregon Health Policy Board are to:

(a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS 413.032 and all of the authority's departmental divisions[*, including the Oregon Health Insurance Exchange described in section 17, chapter 595, Oregon Laws 2009*].

[*(b) Develop and submit a plan to the Legislative Assembly by December 31, 2010, to provide and fund access to affordable, quality health care for all Oregonians by 2015.*]

[*(c) Develop a program to provide health insurance premium assistance to all low and moderate income individuals who are legal residents of Oregon.*]

[*(d)*] **(b)** Establish and continuously refine uniform, statewide health care quality standards for use by all purchasers of health care, third-party payers and health care providers as quality performance benchmarks.

[*(e)*] **(c)** Establish evidence-based clinical standards and practice guidelines that may be used by providers.

[*(f)*] **(d)** Approve and monitor community-centered health initiatives described in ORS 413.032 [*(1)(g)*] that are consistent with public health goals, strategies, programs and performance standards adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and shall regularly report to the Legislative Assembly on the accomplishments and needed changes to the initiatives.

[*(g)*] **(e)** Establish cost containment mechanisms to reduce health care costs.

[*(h)*] **(f)** Ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by the expansion in health coverage, health care system transformations, an increasingly diverse population and an aging workforce.

[*(i)*] **(g)** Work with the Oregon congressional delegation to advance the adoption of changes in federal law or policy to promote Oregon's comprehensive health reform plan.

[*(j) Establish a health benefit package in accordance with ORS 413.064 to be used as the baseline for all health benefit plans offered through the Oregon Health Insurance Exchange.*]

[*(k) Develop and submit a plan to the Legislative Assembly by December 31, 2010, with recommended policies and procedures for the Oregon Health Insurance Exchange developed in accordance with section 17, chapter 595, Oregon Laws 2009.*]

[*(L) Develop and submit a plan to the Legislative Assembly by December 31, 2010, with recommendations for the development of a publicly owned health benefit plan that operates in the exchange under the same rules and regulations as all health insurance plans offered through the exchange, including fully allocated fixed and variable operating and capital costs.*]

[*(m)*] **(h)** By December 31, 2010, investigate and report to the Legislative Assembly, and annually thereafter, on the feasibility and advisability of future changes to the health insurance market in Oregon, including but not limited to the following:

(A) A requirement for every resident to have health insurance coverage.

[*(B) A payroll tax as a means to encourage employers to continue providing health insurance to their employees.*]

[*(C) Expansion of the exchange to include a program of premium assistance and to advance reforms of the insurance market.*]

[*(D)*] **(B)** The implementation of a system of interoperable electronic health records utilized by all health care providers in this state.

[*(n)*] **(i)** Meet cost-containment goals by structuring reimbursement rates to reward comprehensive management of diseases, quality outcomes and the efficient use of resources by promoting

cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations.

[*(o)*] **(j)** Oversee the expenditure of moneys from the Health Care Workforce Strategic Fund to support grants to primary care providers and rural health practitioners, to increase the number of primary care educators and to support efforts to create and develop career ladder opportunities.

[*(p)*] **(k)** Work with the Public Health Benefit Purchasers Committee, administrators of the medical assistance program and the Department of Corrections to identify uniform contracting standards for health benefit plans that achieve maximum quality and cost outcomes and align the contracting standards for all state programs to the greatest extent practicable.

(2) The Oregon Health Policy Board is authorized to:

(a) Subject to the approval of the Governor **and the Affordable Health Care for All Oregon Board established in section 5 of this 2011 Act**, organize and reorganize the authority as the **Oregon Health Policy** Board considers necessary to properly conduct the work of the authority.

(b) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the board's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

(3) If the board or the authority is unable to perform, in whole or in part, any of the duties described in ORS 413.006 to 413.064 without federal approval, the board is authorized to request waivers or other approval necessary to perform those duties. The board shall implement any portions of those duties not requiring legislative authority or federal approval, to the extent practicable.

(4) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.064 and by other statutes.

(5) The board shall consult with the Department of Consumer and Business Services in completing the [*tasks*] **task** set forth in subsection [*(1)(j), (k) and (m)(A) and (C)*] **(1)(h)(A)** of this section.

SECTION 42. ORS 413.017 is amended to read:

413.017. (1) The Oregon Health Policy Board shall establish the committees described in subsections (2) and (3) of this section.

(2)(a) The Public Health Benefit Purchasers Committee shall include individuals who purchase health care for the following:

(A) The Public Employees' Benefit Board.

(B) The Oregon Educators Benefit Board.

(C) Trustees of the Public Employees Retirement System.

(D) A city government.

(E) A county government.

(F) A special district.

(G) Any private nonprofit organization that receives the majority of its funding from the state and requests to participate on the committee.

(b) The Public Health Benefit Purchasers Committee shall:

(A) Identify and make specific recommendations to achieve uniformity across all public health benefit plan designs based on the best available clinical evidence, recognized best practices for

health promotion and disease management, demonstrated cost-effectiveness and shared demographics among the enrollees within the pools covered by the benefit plans.

(B) Develop an action plan for ongoing collaboration to implement the benefit design alignment described in subparagraph (A) of this paragraph and shall leverage purchasing to achieve benefit uniformity if practicable.

(C) Continuously review and report to the Oregon Health Policy Board on the committee's progress in aligning benefits while minimizing the cost shift to individual purchasers of insurance without shifting costs to the private sector [*or the Oregon Health Insurance Exchange*].

(c) The Oregon Health Policy Board shall work with the Public Health Benefit Purchasers Committee to identify uniform provisions for state and local public contracts for health benefit plans that achieve maximum quality and cost outcomes. The board shall collaborate with the committee to develop steps to implement joint contract provisions. The committee shall identify a schedule for the implementation of contract changes. The process for implementation of joint contract provisions must include a review process to protect against unintended cost shifts to enrollees or agencies.

(d) Proposals and plans developed in accordance with this subsection shall be completed by October 1, 2010, and shall be submitted to the Oregon Health Policy Board for its approval and possible referral to the Legislative Assembly no later than December 31, 2010.

(3)(a) The Health Care Workforce Committee shall include individuals who have the collective expertise, knowledge and experience in a broad range of health professions, health care education and health care workforce development initiatives.

(b) The Health Care Workforce Committee shall coordinate efforts to recruit and educate health care professionals and retain a quality workforce to meet the demand that will be created by the expansion in health care coverage, system transformations and an increasingly diverse population.

(c) The Health Care Workforce Committee shall conduct an inventory of all grants and other state resources available for addressing the need to expand the health care workforce to meet the needs of Oregonians for health care.

(4) Members of the committees described in subsections (2) and (3) of this section who are not members of the Oregon Health Policy Board are not entitled to compensation but shall be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495.

SECTION 43. ORS 413.032 is amended to read:

413.032. (1) The Oregon Health Authority is established. The authority shall:

(a) Carry out policies adopted by the Oregon Health Policy Board **and the Affordable Health Care for All Oregon Board**;

[*(b) Develop a plan for the Oregon Health Insurance Exchange in accordance with section 17, chapter 595, Oregon Laws 2009;*]

[*(c)*] **(b)** Administer the Oregon Prescription Drug Program;

[*(d)*] **(c)** Administer the Family Health Insurance Assistance Program;

[*(e)*] **(d)** Provide regular reports to the **Oregon Health Policy** Board with respect to the performance of health services contractors serving recipients of medical assistance, including reports of trends in health services and enrollee satisfaction;

[*(f)*] **(e)** Guide and support, with the authorization of the **Oregon Health Policy** Board, community-centered health initiatives designed to address critical risk factors, especially those that contribute to chronic disease;

[*(g)*] **(f)** Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the Social Security Act and administer medical assistance under ORS chapter 414;

[*(h)*] **(g)** In consultation with the Director of the Department of Consumer and Business Services, periodically review and recommend standards and methodologies to the Legislative Assembly for:

(A) Review of administrative expenses of health insurers;

(B) Approval of rates; and

(C) Enforcement of rating rules adopted by the Department of Consumer and Business Services;

[*(i)*] **(h)** Structure reimbursement rates for providers that serve recipients of medical assistance to reward comprehensive management of diseases, quality outcomes and the efficient use of resources and to promote cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations; **and**

[*(j)*] **(i)** Guide and support community three-share agreements in which an employer, state or local government and an individual all contribute a portion of a premium for a community-centered health initiative or for insurance coverage.[*; and*]

[*(k) Develop, in consultation with the Department of Consumer and Business Services and the Health Insurance Reform Advisory Committee, one or more products designed to provide more affordable options for the small group market.*]

(2) The Oregon Health Authority is authorized to:

(a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate health care reform in Oregon and to provide comparative cost and quality information to consumers, providers and purchasers of health care about Oregon's health care systems and health plan networks in order to provide comparative information to consumers.

(b) Develop uniform contracting standards for the purchase of health care, including the following:

(A) Uniform quality standards and performance measures;

(B) Evidence-based guidelines for major chronic disease management and health care services with unexplained variations in frequency or cost;

(C) Evidence-based effectiveness guidelines for select new technologies and medical equipment; and

(D) A statewide drug formulary that may be used by publicly funded health benefit plans.

(c) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the authority's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

(3) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Authority by ORS 413.006 to 413.064 **or section 10 of this 2011 Act** or by other statutes.

SECTION 44. ORS 413.032, as amended by section 43 of this 2011 Act, is amended to read:

413.032. (1) The Oregon Health Authority is established. The authority shall:

(a) Carry out policies adopted by the Oregon Health Policy Board and the Affordable Health Care for All Oregon Board;

(b) Implement and administer the Affordable Health Care for All Oregon Plan established in section 1 of this 2011 Act;

[*(b)*] **(c)** Administer the Oregon Prescription Drug Program;

[*(c) Administer the Family Health Insurance Assistance Program;*]

(d) Provide regular reports to the Oregon Health Policy Board with respect to the performance of health services contractors serving recipients of medical assistance, including reports of trends in health services and enrollee satisfaction;

(e) Guide and support, with the authorization of the Oregon Health Policy Board, community-centered health initiatives designed to address critical risk factors, especially those that contribute to chronic disease;

(f) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the Social Security Act and administer medical assistance under ORS chapter 414;

(g) In consultation with the Director of the Department of Consumer and Business Services, periodically review and recommend standards and methodologies to the Legislative Assembly for:

(A) Review of administrative expenses of health insurers;

(B) Approval of rates; and

(C) Enforcement of rating rules adopted by the Department of Consumer and Business Services;

(h) Structure reimbursement rates for providers that serve recipients of medical assistance to reward comprehensive management of diseases, quality outcomes and the efficient use of resources and to promote cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations; and

(i) Guide and support community three-share agreements in which an employer, state or local government and an individual all contribute a portion of a premium for a community-centered health initiative or for insurance coverage.

(2) The Oregon Health Authority is authorized to:

(a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate health care reform in Oregon and to provide comparative cost and quality information to consumers, providers and purchasers of health care about Oregon's health care systems and health plan networks in order to provide comparative information to consumers.

(b) Develop uniform contracting standards for the purchase of health care, including the following:

(A) Uniform quality standards and performance measures;

(B) Evidence-based guidelines for major chronic disease management and health care services with unexplained variations in frequency or cost;

(C) Evidence-based effectiveness guidelines for select new technologies and medical equipment; and

(D) A statewide drug formulary that may be used by publicly funded health benefit plans.

(c) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the authority's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

(3) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Authority by ORS 413.006 to 413.064 or section 10 of this 2011 Act or by other statutes.

SECTION 45. ORS 413.033 is amended to read:

413.033. (1) The Oregon Health Authority is under the supervision and control of a director, who is responsible for the performance of the duties, functions and powers of the authority.

(2) The Governor shall appoint the Director of the Oregon Health Authority, who holds office at the pleasure of the Governor **and the Affordable Health Care for All Oregon Board**. The appointment of the director shall be subject to confirmation by the Senate in the manner provided by ORS 171.562 and 171.565.

(3) The director shall have the power to:

(a) Contract for and procure, on a fee or part-time basis, or both, such actuarial, technical or other professional services as may be required for the discharge of duties.

(b) Obtain such other services as the director considers necessary or desirable, including participation in organizations of state insurance supervisory officials and appointment of advisory committees. A member of an advisory committee so appointed shall receive no compensation for services as a member, but, subject to any other applicable law regulating travel and other expenses of state officers, shall receive actual and necessary travel and other expenses incurred in the performance of official duties.

(4) The director may apply for, receive and accept grants, gifts or other payments, including property or services from any governmental or other public or private person and may make arrangement for the use of the receipts, including the undertaking of special studies and other projects relating to the costs of health care, access to health care, public health and health care reform.

SECTION 46. ORS 413.201 is amended to read:

413.201. (1) The Oregon Health Authority is responsible for statewide outreach and marketing of the Health Care for All Oregon Children program established in ORS 414.231 [*and administered by the authority and the Office of Private Health Partnerships*] with the goal of enrolling in those programs all eligible children residing in this state.

(2) To maximize the enrollment and retention of eligible children in the Health Care for All Oregon Children program, the authority shall develop and administer a grant program to provide funding to organizations and community based groups to deliver culturally specific and targeted outreach and direct application assistance to:

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

(b) Children living in geographic isolation; and

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

SECTION 47. ORS 414.041 is amended to read:

414.041. (1) The Department of Human Services, under the direction of the Oregon Health Policy Board and in collaboration with the Oregon Health Authority, shall implement a streamlined and simple application process for the medical assistance [*and premium assistance programs*] **program** administered by the Oregon Health Authority [*and the Office of Private Health Partnerships*]. The process shall include, but not be limited to:

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

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

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

(2) In developing the simplified application forms, the department shall consult with persons not

employed by the department who have experience in serving vulnerable and hard-to-reach populations.

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

SECTION 48. ORS 414.231 is amended to read:

414.231. (1) As used in this section[*:*]**,**

[*(a)*] "child" means a person under 19 years of age.

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

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

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

[*(b) A private health option administered by the Office of Private Health Partnerships under ORS 414.826.*]

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

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

(b) The Department of Human Services shall reenroll a child for successive 12-month periods of enrollment as long as the child is eligible for medical assistance on the date of reenrollment.

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

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

SECTION 49. Section 1, chapter 867, Oregon Laws 2009, as amended by section 46, chapter 828, Oregon Laws 2009, and section 2, chapter 73, Oregon Laws 2010, is amended to read:

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

(2) Amounts in the Health System Fund are continuously appropriated to the Oregon Health Authority for the purpose of funding the Health Care for All Oregon Children program established in ORS 414.231, health services described in ORS 414.705 (1)(a) to (j) and other health services. Moneys in the fund may also be used by the authority to:

(a) Provide grants to community health centers and safety net clinics under ORS 413.225.

(b) Pay refunds due under section 41, chapter 736, Oregon Laws 2003, and under section 11, chapter 867, Oregon Laws 2009.

(c) Pay administrative costs incurred by the authority to administer the assessment in section 9, chapter 867, Oregon Laws 2009.

(d) Provide health services described in ORS 414.705 to individuals described in ORS 414.025 (2)(f)(B).

[*(3) The authority shall develop a system for reimbursement by the authority to the Office of Private*

Health Partnerships out of the Health System Fund for costs associated with administering the private health option pursuant to ORS 414.826.]

SECTION 50. ORS 430.315 is amended to read:

430.315. The Legislative Assembly finds alcoholism or drug dependence is an illness. The alcoholic or drug-dependent person is ill and should be afforded treatment for that illness. To the greatest extent possible, the least costly settings for treatment, outpatient services and residential facilities shall be widely available and utilized except when contraindicated because of individual health care needs. State agencies that purchase treatment for alcoholism or drug dependence shall develop criteria consistent with this policy in consultation with the Oregon Health Authority. In [*reviewing applications for*] **developing policies and approving the adoption of rules for** certificate of need, the [*Director of the Oregon Health Authority*] **Affordable Health Care for All Oregon Board** shall take this policy into account.

SECTION 51. ORS 433.443 is amended to read:

433.443. (1) As used in this section:

(a) "Covered entity" means:

(A) The [*Children's Health Insurance Program*] **Oregon Health Authority**;

(B) The [*Family Health Insurance Assistance Program established under ORS 414.842*] **Department of Human Services**;

(C) A health insurer that is an insurer as defined in ORS 731.106 and that issues health insurance as defined in ORS 731.162; **and**

[*(D) The state medical assistance program; and*]

[*(E)*] **(D)** A health care provider.

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

(A) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

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

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

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

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

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

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

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

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

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

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

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

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

(N) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

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

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

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

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

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

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

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

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

(W) A pharmacy as defined in ORS 689.005;

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

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

(c) "Individual" means a natural person.

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

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

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

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

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

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

(e) "Legal representative" means attorney at law, person holding a general power of attorney, guardian, conservator or any person appointed by a court to manage the personal or financial affairs of a person, or agency legally responsible for the welfare or support of a person.

(2)(a) During a public health emergency declared under ORS 433.441, the Public Health Director may, as necessary to appropriately respond to the public health emergency:

(A) Adopt reporting requirements for and provide notice of those requirements to health care providers, institutions and facilities for the purpose of obtaining information directly related to the public health emergency;

(B) After consultation with appropriate medical experts, create and require the use of diagnostic and treatment protocols to respond to the public health emergency and provide notice of those protocols to health care providers, institutions and facilities;

(C) Order, or authorize local public health administrators to order, public health measures appropriate to the public health threat presented;

(D) Upon approval of the Governor, take other actions necessary to address the public health

emergency and provide notice of those actions to health care providers, institutions and facilities, including public health actions authorized by ORS 431.264;

(E) Take any enforcement action authorized by ORS 431.262, including the imposition of civil penalties of up to $500 per day against individuals, institutions or facilities that knowingly fail to comply with requirements resulting from actions taken in accordance with the powers granted to the Public Health Director under subparagraphs (A), (B) and (D) of this paragraph; and

(F) The authority granted to the Public Health Director under this section:

(i) Supersedes any authority granted to a local public health authority if the local public health authority acts in a manner inconsistent with guidelines established or rules adopted by the director under this section; and

(ii) Does not supersede the general authority granted to a local public health authority or a local public health administrator except as authorized by law or necessary to respond to a public health emergency.

(b) The authority of the Public Health Director to take administrative action, and the effectiveness of any action taken, under paragraph (a)(A), (B), (D), (E) and (F) of this subsection terminates upon the expiration of the proclaimed state of public health emergency, unless the actions are continued under other applicable law.

(3) Civil penalties under subsection (2) of this section shall be imposed in the manner provided in ORS 183.745. The Public Health Director must establish that the individual, institution or facility subject to the civil penalty had actual notice of the action taken that is the basis for the penalty. The maximum aggregate total for penalties that may be imposed against an individual, institution or facility under subsection (2) of this section is $500 for each day of violation, regardless of the number of violations of subsection (2) of this section that occurred on each day of violation.

(4)(a) During a proclaimed state of public health emergency, the Public Health Director and local public health administrators shall be given immediate access to individually identifiable health information necessary to:

(A) Determine the causes of an illness related to the public health emergency;

(B) Identify persons at risk;

(C) Identify patterns of transmission;

(D) Provide treatment; and

(E) Take steps to control the disease.

(b) Individually identifiable health information accessed as provided by paragraph (a) of this subsection may not be used for conducting nonemergency epidemiologic research or to identify persons at risk for post-traumatic mental health problems, or for any other purpose except the purposes listed in paragraph (a) of this subsection.

(c) Individually identifiable health information obtained by the Public Health Director or local public health administrators under this subsection may not be disclosed without written authorization of the identified individual except:

(A) Directly to the individual who is the subject of the information or to the legal representative of that individual;

(B) To state, local or federal agencies authorized to receive such information by state or federal law;

(C) To identify or to determine the cause or manner of death of a deceased individual; or

(D) Directly to a health care provider for the evaluation or treatment of a condition that is the subject of a proclamation of a state of public health emergency issued under ORS 433.441.

(d) Upon expiration of the state of public health emergency, the Public Health Director or local public health administrators may not use or disclose any individually identifiable health information that has been obtained under this section. If a state of emergency that is related to the state of public health emergency has been declared under ORS 401.165, the Public Health Director and local public health administrators may continue to use any individually identifiable information obtained as provided under this section until termination of the state of emergency.

(5) All civil penalties recovered under this section shall be paid into the State Treasury and credited to the General Fund and are available for general governmental expenses.

(6) The Public Health Director may request assistance in enforcing orders issued pursuant to this section from state or local law enforcement authorities. If so requested by the Public Health Director, state and local law enforcement authorities, to the extent resources are available, shall assist in enforcing orders issued pursuant to this section.

(7) If the Oregon Health Authority adopts temporary rules to implement the provisions of this section, the rules adopted are not subject to the provisions of ORS 183.335 (6)(a). The authority may amend temporary rules adopted pursuant to this subsection as often as necessary to respond to the public health emergency.

SECTION 52. ORS 442.015 is amended to read:

442.015. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, with intention of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

(2) "Affected persons" has the same meaning as given to "party" in ORS 183.310.

(3)(a) "Ambulatory surgical center" means a facility or portion of a facility that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

(b) "Ambulatory surgical center" does not mean:

(A) Individual or group practice offices of private physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a physician's or dentist's office using local anesthesia or conscious sedation; or

(B) A portion of a licensed hospital designated for outpatient surgical treatment.

(4) "Budget" means the projections by the hospital for a specified future time period of expenditures and revenues with supporting statistical indicators.

(5) "Develop" means to undertake those activities that on their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, as defined under applicable state law, in relation to the offering of such a health service.

(6) "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a donation or grant in lieu of an expenditure but not including any interest thereon.

(7) "Freestanding birthing center" means a facility licensed for the primary purpose of performing low risk deliveries.

(8) "Governmental unit" means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

(9) "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. "Gross revenue" does not include contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

(10)(a) "Health care facility" means:

(A) A hospital;

(B) A long term care facility;

(C) An ambulatory surgical center;

(D) A freestanding birthing center; or

(E) An outpatient renal dialysis center.

(b) "Health care facility" does not mean:

(A) A residential facility licensed by the Department of Human Services or the Oregon Health Authority under ORS 443.415;

(B) An establishment furnishing primarily domiciliary care as described in ORS 443.205;

(C) A residential facility licensed or approved under the rules of the Department of Corrections;

(D) Facilities established by ORS 430.335 for treatment of substance abuse disorders; or

(E) Community mental health programs or community developmental disabilities programs established under ORS 430.620.

(11) "Health maintenance organization" or "HMO" means a public organization or a private organization organized under the laws of any state that:

(a) Is a qualified HMO under section 1310 (d) of the U.S. Public Health Services Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(12) "Health services" means clinically related diagnostic, treatment or rehabilitative services, and includes alcohol, drug or controlled substance abuse and mental health services that may be provided either directly or indirectly on an inpatient or ambulatory patient basis.

(13) "Hospital" means:

(a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:

(A) Medical;

(B) Nursing;

(C) Laboratory;

(D) Pharmacy; and

(E) Dietary; or

(b) A special inpatient care facility as that term is defined by the Oregon Health Authority by rule.

(14) "Institutional health services" means health services provided in or through health care facilities and includes the entities in or through which such services are provided.

(15) "Intermediate care facility" means a facility that provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

(16) "Long term care facility" means a facility with permanent facilities that include inpatient beds, providing medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director of Human Services, to provide treatment for two or more unrelated patients. "Long term care facility" includes skilled nursing facilities and intermediate care facilities but may not be construed to include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

[*(17) "New hospital" means a facility that did not offer hospital services on a regular basis within its service area within the prior 12-month period and is initiating or proposing to initiate such services. "New hospital" also includes any replacement of an existing hospital that involves a substantial increase or change in the services offered.*]

[*(18) "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. "New skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period.*]

[*(19)*] **(17)** "Offer" means that the health care facility holds itself out as capable of providing, or as having the means for the provision of, specified health services.

[*(20)*] **(18)** "Outpatient renal dialysis facility" means a facility that provides renal dialysis services directly to outpatients.

[*(21)*] **(19)** "Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation, of a state.

[*(22)*] **(20)** "Skilled nursing facility" means a facility or a distinct part of a facility, that is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or an institution that provides rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.

SECTION 53. ORS 734.790 is amended to read:

734.790. (1) ORS 734.750 to 734.890 provide coverage to the following persons for policies and contracts specified in subsection (2) of this section:

(a) To a person who is a resident, if the person is an owner of or a certificate holder under the policy or contract or, in the case of an unallocated annuity contract, an employee participating in

a governmental retirement plan established under section 401, 403(b) or 457 of the United States Internal Revenue Code or the beneficiaries of each such individual if deceased.

(b) To a person who is not a resident, if the person is an owner of or a certificate holder under the policy or contract or, in the case of an unallocated annuity contract, an employee participating in a governmental retirement plan established under section 401, 403(b) or 457 of the United States Internal Revenue Code or the beneficiaries of each such individual if deceased. This paragraph applies to a person who is not a resident only if all of the following conditions are met:

(A) The insurer that issued the policy or contract must be a domestic insurer.

(B) The insurer must never have held a license or certificate of authority in the state in which the person resides.

(C) The state in which the person resides must have an association similar to the Oregon Life and Health Insurance Guaranty Association.

(D) The person must not be eligible for coverage by the association in the state in which the person resides, as described in subparagraph (C) of this paragraph.

(c) To a person who, regardless of where the person resides, is a beneficiary, assignee or payee of the persons covered under paragraph (a) or (b) of this subsection. This paragraph does not include a nonresident certificate holder under a group policy or contract.

(2) ORS 734.750 to 734.890 provide coverage to the persons specified in subsection (1) of this section for direct life insurance, including annuity, policies, health insurance policies, and contracts supplemental to life and health insurance policies, issued by authorized insurers.

(3) ORS 734.750 to 734.890 do not provide coverage for:

(a) That portion or part of a variable life insurance or variable annuity policy not guaranteed by an insurer.

(b) That portion or part of any policy or contract under which the risk is borne by the policyholder.

(c) Any policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued.

(d) Any policy or contract issued by a health care service contractor complying with ORS 750.005 to 750.095.

(e) Any policy or contract issued by a fraternal benefit society.

(f) Any portion of a policy or contract to the extent that the rate of interest on which it is based:

(A) Exceeds, when averaged over the period of four years prior to the date on which the association becomes obligated with respect to the policy or contract, a rate of interest determined by subtracting four percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for a lesser period if the policy or contract was issued less than four years before the association became obligated; and

(B) Exceeds, on and after the date on which the association becomes obligated with respect to the policy or contract, the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available.

(g) Any plan or program of an employer, association or similar entity to provide life, health or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association or similar entity under any of the following:

(A) A multiple employer welfare arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended.

(B) A minimum premium group insurance plan.

(C) A stop-loss group insurance plan.

(D) An administrative services only contract.

(h) Any portion of a policy or contract to the extent that it provides dividends or experience rating credits, or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract.

(i) Any policy or contract issued in this state by a member insurer at a time that it did not have a certificate of authority to issue the policy or contract in this state.

(j) Any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation.

(k) Any portion of any unallocated annuity contract that is issued to or in connection with a specific employee, union or association of natural persons benefit plan, other than a government retirement plan referred to in subsection (1) of this section, or a government lottery.

[*(L) Any coverage issued by the Oregon Medical Insurance Pool.*]

(4) As used in this section, "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

SECTION 54. ORS 743.402 is amended to read:

743.402. Nothing in ORS 743.405 to 743.498, 743A.160 and 743A.164 shall apply to or affect:

(1) Any workers' compensation insurance policy or any liability insurance policy with or without supplementary expense coverage therein;

(2) Any policy of reinsurance;

(3) Any blanket or group policy of insurance; or

(4) Any life insurance policy, or policy supplemental thereto which contains only such provisions relating to health insurance as:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident; or

(b) Operate to safeguard such policy against lapse, or to give a special surrender value or special benefit or an annuity in the event the insured shall become totally and permanently disabled, as defined by the policy or supplemental policy.

[*(5) Coverage under ORS 735.600 to 735.650.*]

SECTION 55. ORS 743.730 is amended to read:

743.730. For purposes of ORS 743.730 to 743.773:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743.736, 743.760 or 743.761, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer and portability health benefit plans.

(2) "Affiliate" of, or person "affiliated" with, a specified person means any carrier who, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with a specified person. For purposes of this definition, "control" has the meaning given that term in ORS 732.548.

(3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health

care service contractor, a period:

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee in lieu of a preexisting conditions provision;

(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

(c) During which no premium shall be charged to the enrollee or late enrollee; and

(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under the plan.

(4) "Basic health benefit plan" means a health benefit plan for small employers that is required to be offered by all small employer carriers and approved by the Director of the Department of Consumer and Business Services in accordance with ORS 743.736.

(5) "Bona fide association" means an association that meets the requirements of 42 U.S.C. 300gg-11 as amended and in effect on July 1, 1997.

(6) "Carrier" means any person who provides health benefit plans in this state, including a licensed insurance company, a health care service contractor, a health maintenance organization, an association or group of employers that provides benefits by means of a multiple employer welfare arrangement or any other person or corporation responsible for the payment of benefits or provision of services.

(7) "Committee" means the Health Insurance Reform Advisory Committee created under ORS 743.745.

(8) "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on July 1, 1997, and includes coverage remaining in force at the time the enrollee obtains new coverage.

(9) "Department" means the Department of Consumer and Business Services.

(10) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(11) "Director" means the Director of the Department of Consumer and Business Services.

(12) "Eligible employee" means an employee of a small employer who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. "Eligible employee" does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the small employer for fewer than 90 days are not eligible employees unless the small employer so allows.

(13) "Employee" means any individual employed by an employer.

(14) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group, individual or portability health benefit plan who has enrolled for coverage under the terms of the plan.

(15) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

(16) "Financially impaired" means a member that is not insolvent and is:

(a) Considered by the Director of the Department of Consumer and Business Services to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(17)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the

director for the carrier's:

(A) Small employer group health benefit plans;

(B) Individual health benefit plans; or

(C) Portability health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design or family composition.

(18) "Group eligibility waiting period" means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

(19)(a) "Health benefit plan" means any hospital expense, medical expense or hospital or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a 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 policies, coverage of CHAMPUS services pursuant to contracts with the federal government, benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan, long term care insurance, hospital indemnity only, short term health insurance policies (the duration of which does not exceed six months including renewals), student accident and health insurance policies, dental only, vision only, a policy of stop-loss coverage that meets the requirements of ORS 742.065, coverage issued as a supplement to liability insurance, 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 that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(c) Nothing in this subsection shall be construed to regulate any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(20) "Health statement" means any information that is intended to inform the carrier or insurance producer of the health status of an enrollee or prospective enrollee in a health benefit plan. "Health statement" includes the standard health statement developed by the Health Insurance Reform Advisory Committee.

(21) "Implementation of chapter 836, Oregon Laws 1989" means that the Health Services Commission has prepared a priority list, the Legislative Assembly has enacted funding of the list and all necessary federal approval, including waivers, has been obtained.

(22) "Individual coverage waiting period" means a period in an individual health benefit plan during which no premiums may be collected and health benefit plan coverage issued is not effective.

(23) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

(24) "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg

as amended and in effect on July 1, 1997;

(b) The individual applies for coverage during an open enrollment period;

(c) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

(d) The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(e) The individual's coverage under Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days of applying for coverage in a group health benefit plan.

(25) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

[*(26) "Oregon Medical Insurance Pool" means the pool created under ORS 735.610.*]

[*(27)*] **(26)** "Preexisting conditions provision" means a health benefit plan provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of ORS 743.730 to 743.773:

(a) Pregnancy does not constitute a preexisting condition except as provided in ORS 743.766;

(b) Genetic information does not constitute a preexisting condition in the absence of a diagnosis of the condition related to such information; and

(c) A preexisting conditions provision shall not be applied to a newborn child or adopted child who obtains coverage in accordance with ORS 743A.090.

[*(28)*] **(27)** "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

[*(29)*] **(28)** "Rating period" means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

[*(30)(a)*] **(29)(a)** "Small employer" means an employer that employed an average of at least two but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least two eligible employees on the date on which coverage takes effect under a health benefit plan issued by a small employer carrier.

(b) Any person that is treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this subsection.

(c) The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

[*(31)*] **(30)** "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers. A fully insured multiple employer welfare arrangement otherwise exempt under ORS 750.303 (4) may elect to be a small employer carrier governed by the provisions of ORS 743.733 to 743.737.

SECTION 56. ORS 743.748 is amended to read:

743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

(E) The average amount of premiums per member per month; and

(F) The percentage change in the average premium per member per month, measured from the previous year.

(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses [*and the assessment against the carrier for the Oregon Medical Insurance Pool*];

(B) The total amount of the surplus maintained;

(C) The total amount of the reserves maintained for unpaid claims;

(D) The total net underwriting gain or loss; and

(E) The carrier's net income after taxes.

(c) The retention rate and claims experience of employer groups within the plan for the preceding year for association health plans as described in ORS 743.734 (7). This information is not subject to public disclosure under ORS chapter 192.

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule after obtaining a recommendation from the Health Insurance Reform Advisory Committee.

(3) The advisory committee shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

(c) Health benefit plans for employers described in ORS 743.733;

(d) Health benefit plans for employers with more than 50 employees; and

(e) Association health plans described in ORS 743.734 (7).

(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet.

SECTION 57. ORS 743.748, as amended by section 10, chapter 752, Oregon Laws 2007, is amended to read:

743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

(E) The average amount of premiums per member per month; and

(F) The percentage change in the average premium per member per month, measured from the previous year.

(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses [*and the assessment against the carrier for the Oregon Medical Insurance Pool*];

(B) The total amount of the surplus maintained;

(C) The total amount of the reserves maintained for unpaid claims;

(D) The total net underwriting gain or loss; and

(E) The carrier's net income after taxes.

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule after obtaining a recommendation from the Health Insurance Reform Advisory Committee.

(3) The advisory committee shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

(c) Health benefit plans for employers described in ORS 743.733; and

(d) Health benefit plans for employers with more than 50 employees.

(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet.

SECTION 58. ORS 743.766 is amended to read:

743.766. (1) All carriers who offer individual health benefit plans and evaluate the health status of individuals for purposes of eligibility shall use the standard health statement established by the Health Insurance Reform Advisory Committee and may not use any other method to determine the health status of an individual. Nothing in this subsection shall prevent a carrier from using health information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

(2)(a) If an individual is accepted for coverage under an individual health benefit plan, the carrier shall not impose exclusions or limitations on coverage greater than:

(A) A preexisting conditions provision that complies with the following requirements:

(i) The provision shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the individual's effective date of coverage; and

(ii) The provision shall terminate its effect no later than six months following the individual's effective date of coverage;

(B) An individual coverage waiting period of 90 days; or

(C) An exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

(b) Pregnancy may constitute a preexisting condition for purposes of this section.

(3) If the carrier elects to restrict coverage through the application of a preexisting conditions provision or an individual coverage waiting period provision, the carrier shall reduce the duration of the provision by an amount equal to the individual's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the effective date of coverage in the new individual health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period.

[*(4) If an eligible prospective enrollee is rejected for coverage under an individual health benefit plan, the prospective enrollee shall be eligible to apply for coverage under the Oregon Medical Insurance Pool.*]

[*(5)*] **(4)** If a carrier accepts an individual for coverage under an individual health benefit plan, the carrier shall renew the policy except:

(a) For nonpayment of the required premiums by the policyholder.

(b) For fraud or misrepresentation by the policyholder.

(c) When the carrier discontinues offering or renewing, or offering and renewing, all of its individual health benefit plans in this state or in a specified service area within this state. In order to discontinue the plans under this paragraph, the carrier:

(A) Must give notice of the decision to the Director of the Department of Consumer and Business Services and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except as provided in subparagraph (C) of this paragraph, in a specified service area;

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area; and

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the individual market in this state or in the specified service area.

(d) When the carrier discontinues offering and renewing an individual health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice of the decision to the director and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other individual health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(e) When the carrier discontinues offering or renewing, or offering and renewing, an individual health benefit plan for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more individual health benefit plans that the carrier offers in the specified service area.

(B) Offer the plans at least 90 days prior to discontinuation.

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(f) When the director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollee; or

(B) Impair the carrier's ability to meet its contractual obligations.

(g) When, in the case of an individual health benefit plan that delivers covered services through a specified network of health care providers, the enrollee no longer lives, resides or works in the service area of the provider network and the termination of coverage is not related to the health status of any enrollee.

(h) When, in the case of a health benefit plan that is offered in the individual market only through one or more bona fide associations, the membership of an individual in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(i) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide service to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

(j) A carrier may modify an individual health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under paragraphs (c) and (e) of this subsection.

[*(6)*] **(5)** Notwithstanding any other provision of this section, a carrier may rescind an individual health benefit plan for fraud, material misrepresentation or concealment by an enrollee.

[*(7)*] **(6)** A carrier that withdraws from the market for individual health benefit plans must continue to renew its portability health benefit plans that have been approved pursuant to ORS 743.761.

[*(8)*] **(7)** A carrier that continues to offer coverage in the individual market in this state is not required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier elects to continue a plan that is closed to new individual policyholders instead of offering alternative coverage in its other individual health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection [*(5)*] **(4)** of this section.

SECTION 59. ORS 743.767 is amended to read:

743.767. Premium rates for individual health benefit plans shall be subject to the following provisions:

(1) Each carrier must file the geographic average rate for its individual health benefit plans for a rating period with the Director of the Department of Consumer and Business Services on or before March 15 of each year.

(2) The premium rates charged during a rating period for individual health benefit plans issued to individuals shall not vary from the individual geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age. For age adjustments to the individual plans, a carrier shall apply uniformly its schedule of age adjustments for individual health benefit plans as approved by the director.

(3) A carrier may not increase the rates of an individual health benefit plan more than once in a 12-month period except as approved by the director. Annual rate increases shall be effective on the anniversary date of the individual health benefit plan's issuance. The percentage increase in the premium rate charged for an individual health benefit plan for a new rating period may not exceed

the sum of the following:

(a) The percentage change in the carrier's geographic average rate for its individual health benefit plan measured from the first day of the prior rating period to the first day of the new period; and

(b) Any adjustment attributable to changes in age and differences in benefit design and family composition.

(4) Notwithstanding any other provision of this section, a carrier that imposes an individual coverage waiting period pursuant to ORS 743.766 may impose a monthly premium rate surcharge for a period not to exceed six months and in an amount not to exceed [*the percentage by which the rates for coverage under the Oregon Medical Insurance Pool exceed the rates established by the Oregon Medical Insurance Pool Board as applicable for individual risks under ORS 735.625*] **a percentage adopted by the director by rule**. The surcharge [*shall*] **must** be approved by the director [*of the Department of Consumer and Business Services*] and, in combination with the waiting period, shall not exceed the actuarial value of a six-month preexisting conditions provision.

SECTION 60. ORS 743.769 is amended to read:

743.769. (1) Each carrier shall actively market all individual health benefit plans sold by the carrier.

(2) Except as provided in subsection (3) of this section, no carrier or insurance producer shall, directly or indirectly, discourage an individual from filing an application for coverage because of the health status, claims experience, occupation or geographic location of the individual.

(3) Subsection (2) of this section does not apply with respect to information provided by a carrier to an individual regarding the established geographic service area or a restricted network provision of a carrier.

(4) Rejection by a carrier of an application for coverage shall be in writing and shall state the reason or reasons for the rejection.

(5) The Director of the Department of Consumer and Business Services may establish by rule additional standards to provide for the fair marketing and broad availability of individual health benefit plans.

(6) A carrier that elects to discontinue offering all of its individual health benefit plans under ORS 743.766 [*(5)(c)*] **(4)(c)** or to discontinue offering and renewing all such plans is prohibited from offering and renewing health benefit plans in the individual market in this state for a period of five years from the date of notice to the director pursuant to ORS 743.766 [*(5)(c)*] **(4)(c)** or, if such notice is not provided, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering individual health benefit plans in this state. This subsection does not apply with respect to a health benefit plan discontinued in a specified service area by a carrier that covers services provided only by a particular organization of health care providers or only by health care providers who are under contract with the carrier.

SECTION 61. ORS 743A.001 is amended to read:

743A.001. (1) [*Except as provided in subsection (4) of this section,*] Any statute described in subsection (2) of this section**:**

(a) That becomes effective on or after July 13, 1985, **except as provided in subsection (4) of this section,** is repealed on the sixth anniversary of the effective date of the statute, unless the Legislative Assembly specifically provides otherwise**; and**

(b) Does not apply to any insurer with respect to services covered in the Affordable Health Care for All Oregon Plan.

(2) This section governs any statute that applies to individual or group health insurance policies and does any of the following:

(a) Requires the insurer to include coverage for specific physical or mental conditions or specific hospital, medical, surgical or dental health services.

(b) Requires the insurer to include coverage for specified persons.

(c) Requires the insurer to provide payment or reimbursement to specified providers of services if the services are within the lawful scope of practice of the provider and the insurance policy provides payment or reimbursement for those services.

(d) Requires the insurer to provide any specific coverage on a nondiscriminatory basis.

(e) Forbids the insurer to exclude from payment or reimbursement any covered services.

(f) Forbids the insurer to exclude coverage of a person because of that person's medical history.

(3) A repeal of a statute under subsection (1) of this section does not apply to any insurance policy in effect on the effective date of the repeal. However, the repeal of the statute applies to a renewal or extension of an existing insurance policy on or after the effective date of the repealer as well as to a new policy issued on or after the effective date of the repealer.

(4) [*This section*] **Subsection (1)(a) of this section** does not apply to ORS 743A.020, 743A.080, 743A.100, 743A.104 and 743A.108.

SECTION 62. ORS 744.704 is amended to read:

744.704. (1) The following persons are exempt from the licensing requirement for third party administrators in ORS 744.702 and from all other provisions of ORS 744.700 to 744.740 applicable to third party administrators:

(a) A person licensed under ORS 744.002 as an adjuster, whose activities are limited to adjustment of claims and whose activities do not include the activities of a third party administrator.

(b) A person licensed as an insurance producer as required by ORS 744.053 and authorized to transact life or health insurance in this state, whose activities are limited exclusively to the sale of insurance and whose activities do not include the activities of a third party administrator.

(c) An employer acting as a third party administrator on behalf of:

(A) Its employees;

(B) The employees of one or more subsidiary or affiliated corporations of the employer; or

(C) The employees of one or more persons with a dealership, franchise, distributorship or other similar arrangement with the employers.

(d) A union, or an affiliate thereof, acting as a third party administrator on behalf of its members.

(e) An insurer that is authorized to transact insurance in this state with respect to a policy issued and delivered in and pursuant to the laws of this state or another state.

(f) A creditor acting on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.

(g) A trust and the trustees, agents and employees of the trust, when acting pursuant to the trust, if the trust is established in conformity with 29 U.S.C. 186.

(h) A trust exempt from taxation under section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to the trust, or a voluntary employees beneficiary association described in section 501(c) of the Internal Revenue Code, its agents and employees and a custodian and the custodian's agents and employees acting pursuant to a custodian account meeting the requirements of section 401(f) of the Internal Revenue Code.

(i) A financial institution that is subject to supervision or examination by federal or state fi-

nancial institution regulatory authorities, or a mortgage lender, to the extent the financial institution or mortgage lender collects and remits premiums to licensed insurance producers or authorized insurers in connection with loan payments.

(j) A company that issues credit cards and advances for and collects premiums or charges from its credit card holders who have authorized collection. The exemption under this paragraph applies only if the company does not adjust or settle claims.

(k) A person who adjusts or settles claims in the normal course of practice or employment as an attorney at law. The exemption under this subsection applies only if the person does not collect charges or premiums in connection with life insurance or health insurance coverage.

(L) A person who acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for which the Insurance Code is preempted pursuant to the Employee Retirement Income Security Act of 1974. A person to whom this paragraph applies must comply with the requirements of ORS 744.714.

[*(m) The Oregon Medical Insurance Pool Board, established under ORS 735.600 to 735.650, and the administering insurer or insurers for the board, for services provided pursuant to ORS 735.600 to 735.650.*]

[*(n)*] **(m)** An entity or association owned by or composed of like employers who administer partially or fully self-insured plans for employees of the employers or association members.

[*(o)*] **(n)** A trust established by a cooperative body formed between cities, counties, districts or other political subdivisions of this state, or between any combination of such entities, and the trustees, agents and employees acting pursuant to the trust.

[*(p)*] **(o)** Any person designated by the Director of the Department of Consumer and Business Services by rule.

(2) A third party administrator is not required to be licensed as a third party administrator in this state if the following conditions are met:

(a) The third party administrator has its principal place of business in another state;

(b) The third party administrator is not soliciting business as a third party administrator in this state; and

(c) In the case of any group policy or plan of insurance serviced by the third party administrator, the lesser of five percent or 100 certificate holders reside in this state.

SECTION 63. ORS 746.600 is amended to read:

746.600. As used in ORS 746.600 to 746.690:

(1)(a) "Adverse underwriting decision" means any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

(A) A declination of insurance coverage.

(B) A termination of insurance coverage.

(C) Failure of an insurance producer to apply for insurance coverage with a specific insurer that the insurance producer represents and that is requested by an applicant.

(D) In the case of life or health insurance coverage, an offer to insure at higher than standard rates.

(E) In the case of insurance coverage other than life or health insurance coverage:

(i) Placement by an insurer or insurance producer of a risk with a residual market mechanism, an unauthorized insurer or an insurer that specializes in substandard risks.

(ii) The charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished.

(iii) An increase in any charge imposed by the insurer for any personal insurance in connection with the underwriting of insurance. For purposes of this sub-subparagraph, the imposition of a service fee is not a charge.

(b) "Adverse underwriting decision" does not mean any of the following actions, but the insurer or insurance producer responsible for the occurrence of the action must nevertheless provide the applicant or policyholder with the specific reason or reasons for the occurrence:

(A) The termination of an individual policy form on a class or statewide basis.

(B) A declination of insurance coverage solely because the coverage is not available on a class or statewide basis.

(C) The rescission of a policy.

(2) "Affiliate of" a specified person or "person affiliated with" a specified person means a person who directly, or indirectly, through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(3) "Applicant" means a person who seeks to contract for insurance coverage, other than a person seeking group insurance coverage that is not individually underwritten.

(4) "Consumer" means an individual, or the personal representative of the individual, who seeks to obtain, obtains or has obtained one or more insurance products or services from a licensee that are to be used primarily for personal, family or household purposes, and about whom the licensee has personal information.

(5) "Consumer report" means any written, oral or other communication of information bearing on a natural person's creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living that is used or expected to be used in connection with an insurance transaction.

(6) "Consumer reporting agency" means a person that, for monetary fees or dues, or on a cooperative or nonprofit basis:

(a) Regularly engages, in whole or in part, in assembling or preparing consumer reports;

(b) Obtains information primarily from sources other than insurers; and

(c) Furnishes consumer reports to other persons.

(7) "Control" means, and the terms "controlled by" or "under common control with" refer to, the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power of the person is the result of a corporate office held in, or an official position held with, the controlled person.

(8) "Covered entity" means:

(a) A health insurer;

(b) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 746.607 or by rules adopted under ORS 746.608; or

(c) A health care clearinghouse.

(9) "Credit history" means any written or other communication of any information by a consumer reporting agency that:

(a) Bears on a consumer's creditworthiness, credit standing or credit capacity; and

(b) Is used or expected to be used, or collected in whole or in part, as a factor in determining eligibility, premiums or rates for personal insurance.

(10) "Customer" means a consumer who has a continuing relationship with a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes.

(11) "Declination of insurance coverage" or "decline coverage" means a denial, in whole or in part, by an insurer or insurance producer of an application for requested insurance coverage.

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

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

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

(b) Case management and care coordination;

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

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating de-identified information; and

(j) Fundraising.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

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

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

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

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

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

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

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

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

(w) A pharmacy as defined in ORS 689.005;

(x) A diabetes self-management program as defined in ORS 743.694; and

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

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

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

(b) Relates to:

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

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

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

(16) "Health insurer" means[*:*]

[*(a)*] an insurer who offers:

[*(A)*] **(a)** A health benefit plan as defined in ORS 743.730;

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

[*(C)*] **(c)** A student health insurance policy;

[*(D)*] **(d)** A Medicare supplemental policy; or

[*(E)*] **(e)** A dental only policy.

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

(17) "Homeowner insurance" means insurance for residential property consisting of a combination of property insurance and casualty insurance that provides coverage for the risks of owning or occupying a dwelling and that is not intended to cover an owner's interest in rental property or commercial exposures.

(18) "Individual" means a natural person who:

(a) In the case of life or health insurance, is a past, present or proposed principal insured or certificate holder;

(b) In the case of other kinds of insurance, is a past, present or proposed named insured or certificate holder;

(c) Is a past, present or proposed policyowner;

(d) Is a past or present applicant;

(e) Is a past or present claimant; or

(f) Derived, derives or is proposed to derive insurance coverage under an insurance policy or certificate that is subject to ORS 746.600 to 746.690.

(19) "Individually identifiable health information" means any oral or written health information that is:

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

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

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

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

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

(20) "Institutional source" means a person or governmental entity that provides information about an individual to an insurer, insurance producer or insurance-support organization, other than:

(a) An insurance producer;

(b) The individual who is the subject of the information; or

(c) A natural person acting in a personal capacity rather than in a business or professional capacity.

(21) "Insurance producer" or "producer" means a person licensed by the Director of the Department of Consumer and Business Services as a resident or nonresident insurance producer.

(22) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model or other process that is based in whole or in part on credit history.

(23)(a) "Insurance-support organization" means a person who regularly engages, in whole or in part, in assembling or collecting information about natural persons for the primary purpose of providing the information to an insurer or insurance producer for insurance transactions, including:

(A) The furnishing of consumer reports to an insurer or insurance producer for use in connection with insurance transactions; and

(B) The collection of personal information from insurers, insurance producers or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(b) "Insurance-support organization" does not mean insurers, insurance producers, governmental institutions or health care providers.

(24) "Insurance transaction" means any transaction that involves insurance primarily for personal, family or household needs rather than business or professional needs and that entails:

(a) The determination of an individual's eligibility for an insurance coverage, benefit or payment; or

(b) The servicing of an insurance application, policy or certificate.

(25) "Insurer" has the meaning given that term in ORS 731.106.

(26) "Investigative consumer report" means a consumer report, or portion of a consumer report, for which information about a natural person's character, general reputation, personal characteristics or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances or others who may have knowledge concerning such items of information.

(27) "Licensee" means an insurer, insurance producer or other person authorized or required to be authorized, or licensed or required to be licensed, pursuant to the Insurance Code.

(28) "Loss history report" means a report provided by, or a database maintained by, an insurance-support organization or consumer reporting agency that contains information regarding the claims history of the individual property that is the subject of the application for a homeowner insurance policy or the consumer applying for a homeowner insurance policy.

(29) "Nonaffiliated third party" means any person except:

(a) An affiliate of a licensee;

(b) A person that is employed jointly by a licensee and by a person that is not an affiliate of the licensee; and

(c) As designated by the director by rule.

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

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(31)(a) "Personal financial information" means:

(A) Information that is identifiable with an individual, gathered in connection with an insurance transaction from which judgments can be made about the individual's character, habits, avocations, finances, occupations, general reputation, credit or any other personal characteristics; or

(B) An individual's name, address and policy number or similar form of access code for the individual's policy.

(b) "Personal financial information" does not mean information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state or local government records, widely distributed media or disclosures to the public that are required by federal, state or local law.

(32) "Personal information" means:

(a) Personal financial information;

(b) Individually identifiable health information; or

(c) Protected health information.

(33) "Personal insurance" means the following types of insurance products or services that are to be used primarily for personal, family or household purposes:

(a) Private passenger automobile coverage;

(b) Homeowner, mobile homeowners, manufactured homeowners, condominium owners and renters coverage;

(c) Personal dwelling property coverage;

(d) Personal liability and theft coverage, including excess personal liability and theft coverage; and

(e) Personal inland marine coverage.

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

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

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

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

(d) A person described in ORS 746.611.

(35) "Policyholder" means a person who:

(a) In the case of individual policies of life or health insurance, is a current policyowner;

(b) In the case of individual policies of other kinds of insurance, is currently a named insured; or

(c) In the case of group policies of insurance under which coverage is individually underwritten, is a current certificate holder.

(36) "Pretext interview" means an interview wherein the interviewer, in an attempt to obtain personal information about a natural person, does one or more of the following:

(a) Pretends to be someone the interviewer is not.

(b) Pretends to represent a person the interviewer is not in fact representing.

(c) Misrepresents the true purpose of the interview.

(d) Refuses upon request to identify the interviewer.

(37) "Privileged information" means information that is identifiable with an individual and that:

(a) Relates to a claim for insurance benefits or a civil or criminal proceeding involving the individual; and

(b) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or a civil or criminal proceeding involving the individual.

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

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

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

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

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

(39) "Residual market mechanism" means an association, organization or other entity involved in the insuring of risks under ORS 735.005 to 735.145, 737.312 or other provisions of the Insurance Code relating to insurance applicants who are unable to procure insurance through normal insurance markets.

(40) "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or a nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure of a premium to be paid as required by the policy.

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

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

(b) Consultations and referrals between health care providers.

SECTION 64. ORS 748.603 is amended to read:

748.603. (1) Societies are governed by this chapter and are exempt from all other provisions of the insurance laws of this state unless expressly designated therein, or unless specifically made applicable by this chapter.

(2) ORS 705.137, 705.139, 731.004 to 731.026, 731.036 to 731.136, 731.146 to 731.156, 731.162, 731.166, 731.170, 731.216 to 731.268, 731.296, 731.324, 731.328, 731.354, 731.356, 731.358, 731.378, 731.380, 731.381, 731.382, 731.385, 731.386, 731.390, 731.394, 731.396, 731.398, 731.402, 731.406, 731.410, 731.422 to 731.434, 731.446 to 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.592, 731.594, 731.730, 731.731, 731.735, 731.737, 731.750, 731.804, 731.844 to 731.992, 731.870,

732.245, 732.250, 732.320, 732.325, 733.010 to 733.050, 733.080, 733.140 to 733.210, 733.220, 733.510, 733.652 to 733.658, 733.730 to 733.750, [*735.600 to 735.650,*] 742.001, 742.003, 742.005, 742.007, 742.009, 742.013 to 742.021, 742.028, 742.038, 742.041, 742.046, 742.051, 742.150 to 742.162 and 744.700 to 744.740 and ORS chapters 734, 743 and 743A apply to fraternal benefit societies to the extent not inconsistent with the express provisions of this chapter.

(3) For the purposes of this subsection and subsection (2) of this section, fraternal benefit societies shall be deemed insurers, and benefit certificates issued by fraternal benefit societies shall be deemed policies.

(4) Every society authorized to do business in this state shall be subject to the provisions of ORS chapter 746 relating to unfair trade practices. However, nothing in ORS chapter 746 shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

SECTION 65. ORS 750.055 is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992 and 731.870.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.188, 743A.190 and 743A.192.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

(g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(h) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

[*(i) ORS 735.600 to 735.650.*]

[*(j)*] **(i)** ORS 743.680 to 743.689.

[*(k)*] **(j)** ORS 744.700 to 744.740.

[*(L)*] **(k)** ORS 743.730 to 743.773.

[*(m)*] **(L)** ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 66. ORS 705.145 is amended to read:

705.145. (1) There is created in the State Treasury a fund to be known as the Consumer and Business Services Fund, separate and distinct from the General Fund. All moneys collected or received by the Department of Consumer and Business Services, except moneys [*collected pursuant to ORS 735.612 and those moneys required*] to be paid into the Workers' Benefit Fund, shall be paid into the State Treasury and credited to the Consumer and Business Services Fund. Moneys in the fund may be invested in the same manner as other state moneys and any interest earned shall be credited to the fund.

(2) The department shall keep a record of all moneys deposited in the Consumer and Business Services Fund that shall indicate, by separate account, the source from which the moneys are derived, the interest earned and the activity or program against which any withdrawal is charged.

(3) If moneys credited to any one account are withdrawn, transferred or otherwise used for purposes other than the program or activity for which the account is established, interest shall accrue on the amount withdrawn from the date of withdrawal and until such funds are restored.

(4) Moneys in the fund are continuously appropriated to the department for its administrative expenses and for its expenses in carrying out its functions and duties under any provision of law.

(5) Except as provided in ORS 705.165, it is the intention of the Legislative Assembly that the performance of the various duties and functions of the department in connection with each of its programs shall be financed by the fees, assessments and charges established and collected in connection with those programs.

(6) There is created by transfer from the Consumer and Business Services Fund a revolving administrative account in the amount of $100,000. The revolving account shall be disbursed by checks or orders issued by the director or the Workers' Compensation Board and drawn upon the State Treasury, to carry on the duties and functions of the department and the board. All checks or orders paid from the revolving account shall be reimbursed by a warrant drawn in favor of the department charged against the Consumer and Business Services Fund and recorded in the appropriate subsidiary record.

(7) For the purposes of ORS chapter 656, the revolving account created pursuant to subsection (6) of this section may also be used to:

(a) Pay compensation benefits; and

(b) Refund to employers amounts paid to the Consumer and Business Services Fund in excess of the amounts required by ORS chapter 656.

(8) Notwithstanding subsections (2), (3) and (5) of this section and except as provided in ORS 455.220 (1), the moneys derived pursuant to ORS 446.003 to 446.200, 446.210, 446.225 to 446.285, 446.395 to 446.420, 446.566 to 446.646, 446.666 to 446.756 and 455.220 (1) and deposited to the fund,

interest earned on those moneys and withdrawals of moneys for activities or programs under ORS 446.003 to 446.200, 446.210, 446.225 to 446.285, 446.395 to 446.420, 446.566 to 446.646 and 446.666 to 446.756, or education and training programs pertaining thereto, must be assigned to a single account within the fund.

(9) Notwithstanding subsections (2), (3) and (5) of this section, the moneys derived pursuant to ORS 455.240 or 460.370 or from state building code or specialty code program fees for which the amount is established by department rule pursuant to ORS 455.020 (2) and deposited to the fund, interest earned on those moneys and withdrawals of moneys for activities or programs described under ORS 455.240 or 446.566 to 446.646, 446.666 to 446.756 and 460.310 to 460.370, structural or mechanical specialty code programs or activities for which a fee is collected under ORS 455.020 (2), or programs described under subsection (10) of this section that provide training and education for persons employed in producing, selling, installing, delivering or inspecting manufactured structures or manufactured dwelling parks or recreation parks, must be assigned to a single account within the fund.

(10) Notwithstanding ORS 279.835 to 279.855 and ORS chapters 279A and 279B, the department may, after consultation with the appropriate specialty code advisory boards established under ORS 455.132, 455.135, 455.138, 480.535 and 693.115, contract for public or private parties to develop or provide training and education programs relating to the state building code and associated licensing or certification programs.

SECTION 67. 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 depen-

dents 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 743.951 and former enrollees shall be eligible for portability coverage in accordance with ORS 735.616;*]

[*(h)*] **(g)** 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)*] **(h)** 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 self-insurance program for tort liability or property damage that is established by two or more affordable housing entities and that complies with the same requirements that public bodies must meet under ORS 30.282 (6). As used in this subsection:

(a) "Affordable housing" means housing projects in which some of the dwelling units may be purchased or rented, with or without government assistance, on a basis that is affordable to individuals of low income.

(b) "Affordable housing entity" means any of the following:

(A) A housing authority created under the laws of this state or another jurisdiction and any agency or instrumentality of a housing authority, including but not limited to a legal entity created to conduct a self-insurance program for housing authorities that complies with ORS 30.282 (6).

(B) A nonprofit corporation that is engaged in providing affordable housing.

(C) A partnership or limited liability company that is engaged in providing affordable housing and that is affiliated with a housing authority described in subparagraph (A) of this paragraph or a nonprofit corporation described in subparagraph (B) of this paragraph if the housing authority or nonprofit corporation:

(i) Has, or has the right to acquire, a financial or ownership interest in the partnership or limited liability company;

(ii) Has the power to direct the management or policies of the partnership or limited liability company;

(iii) Has entered into a contract to lease, manage or operate the affordable housing owned by the partnership or limited liability company; or

(iv) Has any other material relationship with the partnership or limited liability company.

(11) A community-based health care initiative approved by the Administrator of the Office for Oregon Health Policy and Research under ORS 735.723 operating a community-based health care improvement program approved by the administrator.

APPROPRIATION

SECTION 68. There is appropriated to the Oregon Health Authority for deposit in the Affordable Health Care for All Oregon Fund established by section 21 of this 2011 Act, for the biennium beginning July 1, 2011, out of the General Fund, the amount of $_____ for the purpose of establishing the Affordable Health Care for All Oregon Board and developing the Affordable Health Care for All Oregon Plan.

REPEALS

SECTION 69. ORS 413.064 and 413.075 and section 17, chapter 595, Oregon Laws 2009, are repealed.

SECTION 70. ORS 414.825, 414.826, 414.828, 414.831, 414.839, 414.841, 414.842, 414.844, 414.846, 414.848, 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866, 414.868, 414.870, 414.872, 735.600, 735.605, 735.610, 735.612, 735.614, 735.615, 735.616, 735.620, 735.625, 735.630, 735.635, 735.640, 735.645, 735.650, 735.700, 735.701, 735.702, 735.703, 735.705, 735.707, 735.709, 735.710, 735.711, 735.712, 735.714 and 746.222 and sections 1, 2, 3, 4 and 5, chapter 47, Oregon Laws 2010, are repealed.

CAPTIONS

SECTION 71. The unit captions used in this 2011 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2011 Act.

OPERATIVE DATE

SECTION 72. Sections 1 and 25 to 37 of this 2011 Act, the amendments to ORS 65.957, 192.519, 243.105, 243.125, 243.135, 243.215, 243.860, 243.864, 243.866, 243.868, 291.055, 413.032, 413.201, 414.041, 414.231, 705.145, 731.036, 734.790, 743.402, 743.730, 743.748, 743.766, 743.767, 743.769, 743A.001, 744.704, 746.600, 748.603 and 750.055 and section 1, chapter 867, Oregon Laws 2009, by sections 13 to 20, 38 to 40, 44, 46 to 49 and 53 to 67 of this 2011 Act and the repeal of ORS 414.825, 414.826, 414.828, 414.831, 414.839, 414.841, 414.842, 414.844, 414.846, 414.848, 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866, 414.868, 414.870, 414.872, 735.600, 735.605, 735.610, 735.612, 735.614, 735.615, 735.616, 735.620, 735.625, 735.630, 735.635, 735.640, 735.645, 735.650, 735.700, 735.701, 735.702, 735.703, 735.705, 735.707, 735.709, 735.710, 735.711, 735.712, 735.714 and 746.222 and sections 1, 2, 3, 4 and 5, chapter 47, Oregon Laws 2010, by section 70 of this 2011 Act become operative January 2, 2014.

1 _____