SENATE AMENDMENTS TO SENATE BILL 88

By COMMITTEE ON HEALTH CARE, HUMAN SERVICES AND RURAL HEALTH POLICY

March 17

On page 1 of the printed bill, line 2, delete "743.655 and 743.911" and insert "414.025, 743.652, 743.653, 743.655 and 743.664".

After line 4, insert:

"**SECTION 1. Section 2 of this 2011 Act is added to and made a part of ORS 743.650 to 743.664.**

"**SECTION 2. The Director of the Department of Consumer and Business Services shall adopt by rule prompt payment requirements for long term care insurance. The rules shall include a definition of 'claim' and a definition of 'clean claim.' In adopting the rules, the director shall consider the prompt payment requirements in long term care insurance model acts developed by the National Association of Insurance Commissioners.**

"**SECTION 3.** ORS 743.652 is amended to read:

"743.652. As used in ORS 743.650 to 743.664, unless the context requires otherwise:

"(1) 'Applicant' means:

"(a) In the case of an individual long term care insurance policy, the person who seeks to contract for benefits; and

"(b) In the case of a group long term care insurance policy, the proposed certificate holder.

"**(2) 'Benefit trigger' means a contractual provision in a long term care insurance policy that conditions the payment of benefits on an insured's inability to perform activities of daily living or on an insured's cognitive impairment. For qualified long term care insurance, the 'benefit trigger' is the determination that an insured is a chronically ill individual, as defined in section 7702B(c) of the Internal Revenue Code.**

"[*(2)*] **(3)** 'Certificate' means any certificate issued under a group long term care insurance policy, if the policy has been delivered or issued for delivery in this state.

"[*(3)*] **(4)** 'Group long term care insurance' means a long term care insurance policy that is delivered or issued for delivery in this state and issued to:

"(a) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations;

"(b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

"(A) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

"(B) Has been maintained in good faith for purposes other than obtaining insurance;

"(c)(A) An association or a trust or the trustee of a fund established, created or maintained for

the benefit of members of one or more associations. Prior to advertising, marketing or offering the policy within this state, the association or associations, or the insurer of the association or associations shall file evidence with the director that the association or associations have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

"(i) The association or associations hold regular meetings not less than annually to further purposes of the members;

"(ii) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

"(iii) The members have voting privileges and representation on the governing board and committees; and

"(B) Sixty days after the filing, the association or associations shall be considered to satisfy the organizational requirements, unless the director makes a finding that the association or associations do not satisfy those organizational requirements; or

"(d) A group other than as described in paragraphs (a), (b) and (c) of this subsection, subject to a finding by the director that:

"(A) The issuance of the group policy is not contrary to the best interest of the public;

"(B) The issuance of the group policy would result in economies of acquisition or administration; and

"(C) The benefits are reasonable in relation to the premiums charged.

"[*(4)*] **(5)** 'Long term care insurance' means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 24 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary services, including but not limited to nursing, diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. 'Long term care insurance' includes group and individual annuities and life insurance policies or riders that provide directly or supplement long term care insurance. 'Long term care insurance' also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity, and qualified long term care insurance contracts. Long term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; or health maintenance organizations, health care service contractors or any similar organization to the extent they are otherwise authorized to issue life or health insurance. 'Long term care insurance' does not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, catastrophic coverage, accident only coverage, specified disease or specified accident coverage or limited benefit health coverage. With regard to life insurance, 'long term care insurance' does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and when neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long term care. Notwithstanding any other provision of ORS 743.650 to 743.664, any product advertised, marketed or offered as long term care insurance is subject to ORS 743.650 to 743.664.

"[*(5)*] **(6)** 'Policy' means any policy, contract, subscriber agreement, rider or indorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital or medical service corporation; prepaid health plan; or health maintenance organization, health care service contractor or any similar organization.

"[*(6)*] **(7)** 'Qualified long term care insurance' means:

"(a) The portion of a life insurance contract that provides long term care insurance coverage by rider or as part of the contract and that satisfies the requirements of section 7702B(b) and (e) of the Internal Revenue Code; or

"(b) Individual or group long term care insurance as defined in this section that meets all of the following requirements of section 7702B(b) of the Internal Revenue Code:

"(A) The only insurance protection provided under the contract is coverage of qualified long term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

"(B) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, or would be reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payer. A contract does not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

"(C) The contract is guaranteed renewable within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code.

"(D) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in subparagraph (E) of this paragraph.

"(E) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract.

"(F) The contract meets the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code.

"**SECTION 4.** ORS 743.653 is amended to read:

"743.653. Group long term care insurance coverage may not be offered to a resident of this state under a group policy issued in another state to a group described in ORS 743.652 [*(3)(d)*] **(4)(d)**, unless this state or another state having statutory and regulatory long term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.".

In line 5, delete "1" and insert "5".

In line 13, delete "denied" and insert "whether the conditions of a benefit trigger have been met".

In line 14, delete "claims".

On page 2, line 4, delete "(3)(a)" and insert "(4)(a)".

In line 9, delete "(3)(a)" and insert "(4)(a)".

On page 3, line 1, delete "(3)(a)" and insert "(4)(a)".

In line 13, delete "(3)(a)" and insert "(4)(a)".

On page 4, line 24, restore the bracketed material.

In lines 25 through 28, delete the boldfaced material.

After line 28, insert:

"(13) Long term care insurance policies shall include a clear description of the process for appealing and resolving disputes regarding whether the conditions of a benefit trigger have been met.".

In line 29, delete "(13)" and insert "(14)".

In line 31, delete "(14)" and insert "(15)".

In line 33, delete "(15)" and insert "(16)".

Delete lines 34 through 45.

On page 5, delete lines 1 through 14 and insert:

"**SECTION 6.** ORS 743.664 is amended to read:

"743.664. (1) Except as provided in subsection (2) of this section, a long term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer must provide a contingent benefit upon lapse that is available for a specified period of time following a substantial increase in premium rates.

"(2) When a group long term care insurance policy is issued, the offer required in subsection (1) of this section must be made to the group policyholder. However, if the policy is issued as group long term care insurance as described in ORS 743.652 [*(3)(d)*] **(4)(d)**, other than to a continuing care retirement community or similar entity, the offering shall be made to each proposed certificate holder.

"(3) The Director of the Department of Consumer and Business Services by rule shall specify:

"(a) The type or types of nonforfeiture benefits to be offered as part of long term care insurance policies and certificates;

"(b) The standards for nonforfeiture benefits; and

"(c) The standards governing contingent benefits upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium increase that triggers a contingent benefit upon lapse as described in subsection (1) of this section.

"(4) This section is exempt from ORS 743A.001.

"**SECTION 7.** ORS 414.025, as amended by section 1, chapter 73, Oregon Laws 2010, is amended to read:

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

"(1) 'Category of aid' means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

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

"(a) Is receiving a category of aid.

"(b) Would be eligible for a category of aid but is not receiving a category of aid.

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

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

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

"(B) Is the spouse of the caretaker relative.

"(f) Is under the age of 21 years and:

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

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

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

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

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

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

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

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

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

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

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

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

"(q) Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to 412.069 and 418.647, whether or not the woman is eligible for cash assistance.

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

"(s) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the

federal Social Security Act or is not a full-time student in a post-secondary education program as defined by the Department of Human Services by rule, but whose family income is less than the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department by rule.

"(t) Would be eligible for a category of aid but for the receipt of qualified long term care insurance benefits under a policy or certificate issued on or after January 1, 2008. As used in this paragraph, 'qualified long term care insurance' means a policy or certificate of insurance as defined in ORS 743.652 [*(6)*] **(7)**.

"(u) Is eligible for the Health Care for All Oregon Children program established in ORS 414.231.

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

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

"(5) 'Medical assistance' means so much of the following medical and remedial care and services as may be prescribed by the Oregon Health Authority according to the standards established pursuant to ORS 413.032, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

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

"(b) Outpatient hospital services;

"(c) Other laboratory and X-ray services;

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

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

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

"(g) Home health care services;

"(h) Private duty nursing services;

"(i) Clinic services;

"(j) Dental services;

"(k) Physical therapy and related services;

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

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

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

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

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

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

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

"(s) Hospice services.

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

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

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

"**SECTION 8. (1) Section 2 of this 2011 Act and the amendments to ORS 743.652, 743.653, 743.655 and 743.664 by sections 3 to 6 of this 2011 Act apply to long term care insurance policies issued or renewed on or after July 1, 2012.**

"(2) The Director of the Department of Consumer and Business Services may take any action necessary after the effective date of this 2011 Act to fully implement section 2 of this 2011 Act and the amendments to ORS 743.652, 743.653, 743.655 and 743.664 by sections 3 to 6 of this 2011 Act on July 1, 2012.".

In line 15, delete "4" and insert "9".
