House Bill 2273

Sponsored by Representative FREEMAN (Presession filed.)

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.**

Requires Oregon Health Authority to continue to contract with dental care organizations to serve medical assistance recipients.

A BILL FOR AN ACT

Relating to prepaid managed care health services organizations; creating new provisions; amending ORS 192.493, 192.579, 414.018, 414.618, 414.631, 414.632, 414.645, 414.647, 416.510, 416.540, 741.300, 741.310, 743.061 and 743.847 and sections 14 and 64, chapter 602, Oregon Laws 2011.

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

SECTION 1. Section 14, chapter 602, Oregon Laws 2011, as amended by section 2, chapter 8, Oregon Laws 2012, is amended to read:

Sec. 14. (1) Notwithstanding ORS 414.631 and 414.651, in any area of the state where a coordinated care organization has not been certified, the Oregon Health Authority shall continue to contract with one or more prepaid managed care health services organizations, as defined in ORS 414.736, that serve the area and that are in compliance with contractual obligations owed to the state or local government.

(2) Prepaid managed care health services organizations contracting with the authority under this section are subject to the applicable requirements for, and are permitted to exercise the rights of, coordinated care organizations under ORS 414.153, 414.625, 414.635, 414.638, 414.651, 414.655, 414.679, 414.712, 414.728, 414.743, 414.746, 414.760, 416.510 to 416.610, 441.094, 442.464, 655.515, 659.830 and 743.847.

(3) The authority may amend contracts that are in place on July 1, 2011, to allow prepaid managed care health services organizations that meet the criteria adopted by the authority under ORS 414.625 to become coordinated care organizations.

(4)**(a)** The authority shall continue to renew the contracts of prepaid managed care health services organizations that have a contract with the authority on July 1, 2011, until**:**

(A) For prepaid managed care health services organizations other than dental care organizations, the earlier of the date the prepaid managed care health services organization becomes a coordinated care organization or July 1, 2014[.]**; and**

(B) For dental care organizations, the date the dental care organization enters into a contract with a coordinated care organization.

(b) Contracts with prepaid managed care health services organizations **other than dental care organizations** must terminate no later than July 1, 2017.

(5) The authority shall continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a con-

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.

tract with a coordinated care organization but no later than July 1, 2013.

(6) Notwithstanding ORS 414.625 (2)(g) and 414.655 (2), the authority shall allow for a period of transition to the full adoption of health information technology by coordinated care organizations and patient centered primary care homes. The authority shall explore options for assisting providers and coordinated care organizations in funding their use of health information technology.

SECTION 2. ORS 414.018 is amended to read:

414.018. (1) It is the intention of the Legislative Assembly to achieve the goals of universal access to an adequate level of high quality health care at an affordable cost.

(2) The Legislative Assembly finds:

(a) A significant level of public and private funds is expended each year for the provision of health care to Oregonians;

(b) The state has a strong interest in assisting Oregon businesses and individuals to obtain reasonably available insurance or other coverage of the costs of necessary basic health care services;

(c) The lack of basic health care coverage is detrimental not only to the health of individuals lacking coverage, but also to the public welfare and the state's need to encourage employment growth and economic development, and the lack results in substantial expenditures for emergency and remedial health care for all purchasers of health care including the state; and

(d) The use of integrated and coordinated health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state.

(3)**(a)** The Legislative Assembly finds that achieving its goals of improving health, increasing the quality, reliability, availability and continuity of care and reducing the cost of care requires an integrated and coordinated health care system in which:

[*(a)*] **(A)** Medical assistance recipients and individuals who are dually eligible for both Medicare and Medicaid participate.

[*(b)*] **(B)** Health care services, other than Medicaid-funded long term care services **and dental services delivered by dental care organizations**, are delivered through coordinated care contracts that use alternative payment methodologies to focus on prevention, improving health equity and reducing health disparities, utilizing patient centered primary care homes, evidence-based practices and health information technology to improve health and health care.

[*(c)*] **(C)** High quality information is collected and used to measure health outcomes, health care quality and costs and clinical health information.

[*(d)*] **(D)** Communities and regions are accountable for improving the health of their communities and regions, reducing avoidable health gaps among different cultural groups and managing health care resources.

[*(e)*] **(E)** Care and services emphasize preventive services and services supporting individuals to live independently at home or in their community.

[*(f)*] **(F)** Services are person centered, and provide choice, independence and dignity reflected in individual plans and provide assistance in accessing care and services.

[*(g)*] **(G)** Interactions between the Oregon Health Authority and coordinated care organizations are done in a transparent and public manner.

[*(h)*] **(H)** Moneys provided by the federal government for medical education are allocated to the institutions that provide the education.

(b) As used in this subsection:

(A) "Community" means the groups within the geographic area served by a coordinated

care organization and includes groups that identify themselves by age, ethnicity, race, economic status, or other defining characteristic that may impact delivery of health care services to the group, as well as the governing body of each county located wholly or partially within the coordinated care organization's service area.

(B) "Region" means the geographical boundaries of the area served by a coordinated care organization as well as the governing body of each county that has jurisdiction over all or part of the coordinated care organization's service area.

(4) The Legislative Assembly further finds that there is an extreme need for a skilled, diverse workforce to meet the rapidly growing demand for community-based health care. To meet that need, this state must:

(a) Build on existing training programs; and

(b) Provide an opportunity for frontline care providers to have a voice in their workplace in order to effectively advocate for quality care.

[*(5) As used in subsection (3) of this section:*]

[*(a) "Community" means the groups within the geographic area served by a coordinated care organization and includes groups that identify themselves by age, ethnicity, race, economic status, or other defining characteristic that may impact delivery of health care services to the group, as well as the governing body of each county located wholly or partially within the coordinated care organization's service area.*]

[*(b) "Region" means the geographical boundaries of the area served by a coordinated care organization as well as the governing body of each county that has jurisdiction over all or part of the coordinated care organization's service area.*]

SECTION 3. ORS 414.618 is amended to read:

414.618. [*(1) In areas that are not served by a coordinated care organization, the Oregon Health Authority may execute prepaid capitated health service contracts for at least hospital or physician medical care, or both, with hospital and medical organizations, health maintenance organizations and any other appropriate public or private persons.*]

[*(2)*] **(1)** For purposes of ORS 279A.025, 279A.140, 414.145 and 414.610 to 414.620, instrumentalities and political subdivisions of the state are authorized to enter into [*prepaid capitated health service*] **dental care organization** contracts with the authority and shall not thereby be considered to be transacting insurance.

[*(3) In the event that there is an insufficient number of qualified bids for coordinated care organizations or prepaid capitated health services contracts for hospital or physician medical care, or both, in some areas of the state, the authority may continue a fee for service payment system.*]

[*(4)*] **(2)** Payments to [*providers*] **dental care organizations** may be subject to contract provisions requiring the retention of a specified percentage in an incentive fund or to other contract provisions by which adjustments to the payments are made based on utilization efficiency.

[*(5)*] **(3)** Contracts described in this section are not subject to ORS chapters 279A and 279B, except that the contracts are subject to ORS 279A.235 and 279A.250 to 279A.290.

SECTION 4. ORS 414.631 is amended to read:

414.631. (1) Except as provided in subsections (2), (3), (4) and (5) of this section and ORS 414.632 (2), a person who is eligible for or receiving health services must be enrolled in a coordinated care organization to receive the health services for which the person is eligible. For purposes of this subsection, Medicaid-funded long term care services **and dental services provided by a dental care organization** do not constitute health services.

(2) Subsections (1) and (4) of this section do not apply to:

(a) A person who is a noncitizen and who is eligible only for labor and delivery services and emergency treatment services;

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

(c) An individual described in ORS 414.632 (2) who is dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly; and

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

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

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

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

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

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

(F) A person with major medical coverage.

(3) Subsection (1) of this section does not apply to a person who resides in an area that is not served by a coordinated care organization or where the organization's provider network is inadequate.

(4) In any area that is not served by a coordinated care organization but is served by a prepaid managed care health services organization, a person must enroll with the prepaid managed care health services organization to receive any of the health services offered by the prepaid managed care health services organization.

(5) As used in this section, "American Indian and Alaskan Native beneficiary" means:

(a) A member of a federally recognized Indian tribe;

(b) An individual who resides in an urban center and:

(A) Is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups whose recognition was terminated since 1940 and those recognized now or in the future by the state in which the member resides, or who is a descendant in the first or second degree of such a member;

(B) Is an Eskimo or Aleut or other Alaskan Native; or

(C) Is determined to be an Indian under regulations promulgated by the United States Secretary of the Interior;

(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose; or

(d) An individual who is considered by the United States Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut or other Alaskan Native.

SECTION 5. ORS 414.632, as amended by section 25, chapter 8, Oregon Laws 2012, is amended to read:

414.632. (1) Subject to the Oregon Health Authority obtaining any necessary authorization from the Centers for Medicare and Medicaid Services, coordinated care organizations that meet the criteria adopted under ORS 414.625 are responsible for providing covered Medicare and Medicaid services, other than Medicaid-funded long term care services **and dental services delivered by dental care organizations**, to members who are dually eligible for Medicare and Medicaid in addition to

medical assistance recipients.

(2) An individual who is dually eligible for Medicare and Medicaid shall be permitted to enroll in and remain enrolled in a:

(a) Program of all-inclusive care for the elderly, as defined in 42 C.F.R. 460.6; and

(b) Medicare Advantage plan, as defined in 42 C.F.R. 422.2, until the plan is fully integrated into a coordinated care organization.

(3) Except for the enrollment in coordinated care organizations of individuals who are dually eligible for Medicare and Medicaid, the rights and benefits of Medicare beneficiaries under Title XVIII of the Social Security Act shall be preserved.

SECTION 6. Section 64, chapter 602, Oregon Laws 2011, as amended by section 70, chapter 602, Oregon Laws 2011, and section 23, chapter 8, Oregon Laws 2012, is amended to read:

Sec. 64. (1) ORS 414.705 is repealed.

(2) Sections 13 and 17, chapter 602, Oregon Laws 2011, are repealed January 2, 2014.

(3) ORS 414.610, [*414.630,*] 414.640, 414.736, 414.738, 414.739 and 414.740 are repealed July 1, 2017.

(4) Section 14, chapter 602, Oregon Laws 2011, as amended by section 2 [*of this 2012 Act*]**, chapter 8, Oregon Laws 2012**, is repealed July 1, 2017.

SECTION 7. ORS 192.493 is amended to read:

192.493. A record of an agency of the executive department as defined in ORS 174.112 that contains the following information is a public record subject to inspection under ORS 192.420 and is not exempt from disclosure under ORS 192.501 or 192.502 except to the extent that the record discloses information about an individual's health or is proprietary to a person:

(1) The amounts determined by an independent actuary retained by the agency to cover the costs of providing each of the following health services under ORS 414.631, 414.651 and 414.688 to 414.750 for the six months preceding the report:

(a) Inpatient hospital services;

(b) Outpatient hospital services;

(c) Laboratory and X-ray services;

(d) Physician and other licensed practitioner services;

(e) Prescription drugs;

(f) Dental services;

(g) Vision services;

(h) Mental health services;

(i) Chemical dependency services;

(j) Durable medical equipment and supplies; and

(k) Other health services provided under a coordinated care organization contract under ORS 414.651 or a contract with a [*prepaid managed care health services*] **dental care** organization;

(2) The amounts the agency and each contractor have paid under each coordinated care organization contract under ORS 414.651 or [*prepaid managed care health services*] **dental care** organization contract for administrative costs and the provision of each of the health services described in subsection (1) of this section for the six months preceding the report;

(3) Any adjustments made to the amounts reported under this section to account for geographic or other differences in providing the health services; and

(4) The numbers of individuals served under each coordinated care organization contract or [*prepaid managed care health services*] **dental care** organization contract, listed by category of in-

dividual.

SECTION 8. ORS 192.579 is amended to read:

192.579. (1) As used in this section, "entity" means a health care provider or a [*prepaid managed care health services*] **dental care** organization[*, as defined in ORS 414.736,*] that provides health care **or dental care** to an individual, if the care is paid for by a state health plan.

(2) Notwithstanding ORS 179.505, an entity may disclose the identity of an individual who receives health care **or dental care** from the entity without obtaining an authorization from the individual, or a personal representative of the individual, to another entity for the purpose of coordinating the health care **or dental care** and treatment provided to the individual by either entity.

SECTION 9. ORS 414.645 is amended to read:

414.645. (1) A [*prepaid managed care health services*] **coordinated care organization and a dental care** organization that contracts with the Oregon Health Authority must maintain a network of providers sufficient in numbers and areas of practice and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to enrollees.

(2) An enrollee may transfer from one organization to another organization no more than once during each enrollment period.

SECTION 10. ORS 414.647 is amended to read:

414.647. (1) The Oregon Health Authority may approve the transfer of 500 or more enrollees from one [*prepaid managed care health services*] **coordinated care organization or dental care** organization to another [*prepaid managed care health services*] **coordinated care organization or dental care** organization if:

(a) The enrollees' provider has contracted with the receiving organization and has stopped accepting patients from or has terminated providing services to enrollees in the transferring organization; and

(b) Enrollees are offered the choice of remaining enrolled in the transferring organization.

(2) Enrollees may not be transferred under this section until the authority has evaluated the receiving organization and determined that the organization meets criteria established by the authority by rule, including but not limited to criteria that ensure that the organization meets the requirements of ORS 414.645 (1).

(3) The authority shall provide notice of a transfer under this section to enrollees that will be affected by the transfer at least 90 days before the scheduled date of the transfer.

SECTION 11. ORS 416.510 is amended to read:

416.510. As used in ORS 416.510 to 416.610, unless the context requires otherwise:

(1) "Action" means an action, suit or proceeding.

(2) "Alternative payment methodology" has the meaning given that term in ORS 414.025.

(3) "Applicant" means an applicant for assistance.

(4) "Assistance" means moneys paid by the Department of Human Services to persons directly and moneys paid by the Oregon Health Authority or by a [*prepaid managed care health services*] **dental care** organization or a coordinated care organization for services provided under contract pursuant to ORS 414.651 to others for the benefit of such persons.

(5) "Authority" means the Oregon Health Authority.

(6) "Claim" means a claim of a recipient of assistance for damages for personal injuries against any person or public body, agency or commission other than the State Accident Insurance Fund

Corporation or Workers' Compensation Board.

(7) "Compromise" means a compromise between a recipient and any person or public body, agency or commission against whom the recipient has a claim.

(8) "Coordinated care organization" means an organization that meets the criteria adopted by the authority under ORS 414.625.

(9) "Judgment" means a judgment in any action or proceeding brought by a recipient to enforce the claim of the recipient.

[*(10) "Prepaid managed care health services organization" means a managed health, dental or mental health care organization that contracted with the authority on a prepaid capitated basis. Prepaid managed care health services organizations may be dental care organizations, fully capitated health plans, mental health organizations or chemical dependency organizations.*]

[*(11)*] **(10)** "Recipient" means a recipient of assistance.

[*(12)*] **(11)** "Settlement" means a settlement between a recipient and any person or public body, agency or commission against whom the recipient has a claim.

SECTION 12. ORS 416.540, as amended by section 27, chapter 8, Oregon Laws 2012, is amended to read:

416.540. (1) Except as provided in subsection (2) of this section and in ORS 416.590, the Department of Human Services and the Oregon Health Authority shall have a lien upon the amount of any judgment in favor of a recipient or amount payable to the recipient under a settlement or compromise for all assistance received by such recipient from the date of the injury of the recipient to the date of satisfaction of such judgment or payment under such settlement or compromise.

(2) The lien does not attach to the amount of any judgment, settlement or compromise to the extent of attorney's fees, costs and expenses incurred by a recipient in securing such judgment, settlement or compromise and to the extent of medical, surgical and hospital expenses incurred by the recipient on account of the personal injuries for which the recipient had a claim.

(3) The authority may assign the lien described in subsection (1) of this section to a [*prepaid managed care health services*] **dental care** organization or a coordinated care organization for medical costs incurred by a recipient:

(a) During a period for which the authority paid a capitation or enrollment fee or a payment using a global payment methodology; and

(b) On account of the personal injury for which the recipient had a claim.

(4) A [*prepaid managed care health services*] **dental care** organization or a coordinated care organization to which the authority has assigned a lien shall notify the authority no later than 10 days after filing notice of a lien.

(5) For the purposes of ORS 416.510 to 416.610, the authority may designate the [*prepaid managed care health services*] **dental care** organization or the coordinated care organization to which a lien is assigned as its designee.

(6) If the authority and a [*prepaid managed care health services*] **dental care** organization or a coordinated care organization both have filed a lien, the authority's lien shall be satisfied first.

SECTION 13. ORS 741.300 is amended to read:

741.300. As used in ORS 741.001 to 741.540:

(1) "Essential health benefits" means the health care services identified by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 18022 or approved by the secretary pursuant to a waiver granted under 42 U.S.C. 18052.

(2) "Health care service contractor" has the meaning given that term in ORS 750.005.

(3) "Health insurance" has the meaning given that term in ORS 731.162, excluding disability income insurance.

(4) "Health insurance exchange" or "exchange" means an American Health Benefit Exchange as described in 42 U.S.C. 18031, 18032, 18033 and 18041 that is operated by the Oregon Health Insurance Exchange Corporation.

(5) "Health plan" means health insurance or health care coverage offered by an insurer.

(6) "Insurer" means an insurer as defined in ORS 731.106 that offers health insurance, a health care service contractor or a [*prepaid managed care health services*] **coordinated care** organization **as defined in ORS 414.025**.

(7) "Insurance producer" has the meaning given that term in ORS 731.104.

[*(8) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.736.*]

[*(9)*] **(8)** "State program" means a program providing medical assistance, as defined in ORS 414.025, and any health plan offered through the Public Employees' Benefit Board or the Oregon Educators Benefit Board.

SECTION 14. ORS 741.310, as amended by section 12, chapter 415, Oregon Laws 2011, section 11, chapter 38, Oregon Laws 2012, and section 97, chapter 107, Oregon Laws 2012, is amended to read:

741.310. (1) The following individuals and groups may purchase qualified health plans through the health insurance exchange:

(a) Individuals and families;

(b) Employers with no more than 100 employees; and

(c) Districts and eligible employees of districts that are subject to ORS 243.886, unless their participation is precluded by federal law.

(2)(a) Only individuals who purchase health plans through the exchange may be eligible to receive premium tax credits under section 36B of the Internal Revenue Code and reduced cost-sharing under 42 U.S.C. 18071.

(b) Only employers that purchase health plans through the exchange may be eligible to receive small employer health insurance credits under section 45R of the Internal Revenue Code.

(3) Only an insurer that has a certificate of authority to transact insurance in this state and that meets applicable federal requirements for participating in the exchange may offer a qualified health plan through the exchange. Any qualified health plan must be certified under subsection (4) of this section. [*Prepaid managed care health services organizations that do not have a certificate of authority to transact insurance may serve only medical assistance recipients through the exchange and may not offer qualified health plans.*]

(4)(a) The Oregon Health Insurance Exchange Corporation shall adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans, including requirements that a qualified health plan provide, at a minimum, essential health benefits and have acceptable consumer and provider satisfaction ratings.

(b) The corporation may limit the number of qualified health plans that may be offered through the exchange as long as the same limit applies to all insurers.

(c) The corporation shall consult with stakeholders, including but not limited to representatives of school administrators, school board members and school employees, regarding the plans that may be offered through the exchange to districts and eligible employees of districts under subsection (1)(c) of this section.

(5) Notwithstanding subsection (4) of this section, the corporation shall certify as qualified a dental only health plan as permitted by federal law.

(6) The corporation shall establish one streamlined and seamless application and enrollment process for both the exchange and the state medical assistance program.

(7) The corporation, in collaboration with the appropriate state authorities, may establish risk mediation programs within the exchange.

(8) The corporation shall establish by rule a process for certifying insurance producers to facilitate the transaction of insurance through the exchange, in accordance with federal standards and policies.

(9) The corporation shall ensure, as required by federal laws, that an insurer charges the same premiums for plans sold through the exchange as for identical plans sold outside of the exchange.

(10) The corporation is authorized to enter into contracts for the performance of duties, functions or operations of the exchange, including but not limited to contracting with:

(a) Insurers that meet the requirements of subsections (3) and (4) of this section, to offer qualified health plans through the exchange; and

(b) Navigators certified by the corporation under ORS 741.002.

(11) The corporation is authorized to apply for and accept federal grants, other federal funds and grants from nongovernmental organizations for purposes of developing, implementing and administering the exchange. Moneys received under this subsection shall be deposited in an account established under ORS 741.101.

SECTION 15. ORS 743.061 is amended to read:

743.061. (1) The Department of Consumer and Business Services may adopt by rule uniform standards applicable to persons listed in subsection (2) of this section for health care financial and administrative transactions, including uniform standards for:

(a) Eligibility inquiry and response;

(b) Claim submission;

(c) Payment remittance advice;

(d) Claims payment or electronic funds transfer;

(e) Claims status inquiry and response;

(f) Claims attachments;

(g) Prior authorization;

(h) Provider credentialing; or

(i) Health care financial and administrative transactions identified by the stakeholder work group described in ORS 743.062.

(2) Any uniform standards adopted under subsection (1) of this section apply to:

(a) Health insurers.

[*(b) Prepaid managed care health services organizations as defined in ORS 414.736.*]

(b) Dental care organizations.

(c) Third party administrators.

(d) Any person or public body that either individually or jointly establishes a self-insurance plan, program or contract, including but not limited to persons and public bodies that are otherwise exempt from the Insurance Code under ORS 731.036.

(e) Health care clearinghouses or other entities that process or facilitate the processing of health care financial and administrative transactions from a nonstandard format to a standard format.

(f) Any other person identified by the department that processes health care financial and administrative transactions between a health care provider and an entity described in this subsection.

(3) In developing or updating any uniform standards adopted under subsection (1) of this section, the department shall consider recommendations from the Oregon Health Authority under ORS 743.062.

SECTION 16. ORS 743.847 is amended to read:

743.847. (1) For the purposes of this section:

(a) "Health insurer" or "insurer" means an employee benefit plan, self-insured plan, managed care organization or group health plan, a third party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service.

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

(b) "Medical assistance" has the meaning given that term in ORS 414.025.

(2) A health insurer is prohibited from considering the availability or eligibility for medical assistance in this [*or any other*] state [*under Medicaid*] **or a similar program of medical assistance in another state** when considering eligibility for coverage or making payments under its group or individual plan for eligible enrollees, subscribers, policyholders or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state [*Medicaid*] **medical assistance** program for health care items or services furnished to an individual, in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) An insurer may not deny a claim submitted by the [*state Medicaid agency, a prepaid managed care health services*] **Oregon Health Authority, the Department of Human Services, a dental care** organization or a coordinated care organization described in ORS 414.651 under subsection (3) of this section based on the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point of sale that is the basis of the claim if:

(a) The claim is submitted by the [*agency*] **authority, the department**, the [*prepaid managed care health services*] **dental care** organization or the coordinated care organization within the three-year period beginning on the date on which the health care item or service was furnished; and

(b) Any action by the [*agency*] **authority, the department**, the [*prepaid managed care health services*] **dental care** organization or the coordinated care organization to enforce its rights with respect to the claim is commenced within six years of the [*agency's or organization's*] submission of the claim.

(5) An insurer must provide to the [*state Medicaid agency*] **authority, the department**, a [*prepaid managed care health services*] **dental care** organization or a coordinated care organization, upon request, the following information:

(a) The period during which a [*Medicaid*] **medical assistance** recipient, the spouse or dependents may be or may have been covered by the plan;

(b) The nature of coverage that is or was provided by the plan; and

(c) The name, address and identifying numbers of the plan.

(6) An insurer may not deny enrollment of a child under the group or individual health plan of the child's parent on the ground that:

(a) The child was born out of wedlock;

(b) The child is not claimed as a dependent on the parent's federal tax return; or

(c) The child does not reside with the child's parent or in the insurer's service area.

(7) When a child has group or individual health coverage through an insurer of a noncustodial parent, the insurer must:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) Make payments on claims submitted in accordance with paragraph (b) of this subsection directly to the custodial parent, the provider or, if a claim is filed by the [*state Medicaid agency*] **authority, the department**, a [*prepaid managed care health services*] **dental care** organization or a coordinated care organization, directly to the [*agency*] **authority, the department** or the organization.

(8) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer must:

(a) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program; and

(c) Not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

(9) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance [*under Medicaid*] and covered for health benefits from the insurer if the requirements are different from requirements applicable to an agent or assignee of any other individual so covered.

(10) The provisions of ORS 743A.001 do not apply to this section.

SECTION 17. The amendments to ORS 192.493, 192.579, 414.618, 414.645, 414.647, 416.510, 416.540, 741.300, 741.310, 743.061 and 743.847 by sections 3 and 7 to 16 of this 2013 Act become operative July 1, 2017.
