81st OREGON LEGISLATIVE ASSEMBLY--2021 Regular Session

House Bill 2041

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of Governor Kate Brown for Department of Consumer and Business Services)

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.**

Transfers duties, functions and powers related to COFA Premium Assistance Program and health insurance exchange from Department of Consumer and Business Services to Oregon Health Authority on June 30, 2021.

Declares emergency, effective on passage.

1 **A BILL FOR AN ACT**

2 Relating to health insurance; creating new provisions; amending ORS 243.142, 411.400, 411.402,
3 411.406, 413.011, 413.032, 414.025, 735.601, 735.608, 735.617, 741.002, 741.003, 741.004, 741.008,
4 741.102, 741.105, 741.107, 741.220, 741.222, 741.300, 741.310, 741.390, 741.400, 741.500, 741.510,
5 741.520, 741.540, 741.802, 741.900, 743.018 and 743B.130; repealing ORS 735.611; and declaring an
6 emergency.

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

8

9 **TRANSFER OF DUTIES FROM DEPARTMENT OF CONSUMER**
10 **AND BUSINESS SERVICES TO OREGON HEALTH AUTHORITY**

11

12 **SECTION 1. The duties, functions and powers of the Department of Consumer and**
13 **Business Services relating to the COFA Premium Assistance Program and the health insur-**
14 **ance exchange are imposed upon, transferred to and vested in the Oregon Health Authority.**

15

16 **TRANSFER OF RECORDS, PROPERTY, EMPLOYEES**

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18 **SECTION 2. (1) The Director of the Department of Consumer and Business Services**
19 **shall:**
20 **(a) Deliver to the Oregon Health Authority all records and property within the jurisdic-**
21 **tion of the director that relate to the duties, functions and powers transferred by section 1**
22 **of this 2021 Act; and**
23 **(b) Transfer to the authority those employees engaged primarily in the exercise of the**
24 **duties, functions and powers transferred by section 1 of this 2021 Act.**
25 **(2) The Director of the Oregon Health Authority shall take possession of the records and**
26 **property and shall take charge of the employees and employ them in the exercise of the du-**
27 **ties, functions and powers transferred by section 1 of this 2021 Act. Notwithstanding ORS**
28 **741.003, the employees shall be employed in the same capacities, positions, classifications and**
29 **steps in which they were employed by the department.**
30 **(3) The Governor shall resolve any dispute between the department and the authority**

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.

relating to transfers of records, property and employees under this section, and the Governor's decision is final.

UNEXPENDED REVENUES

SECTION 3. (1) The unexpended balances of amounts authorized to be expended by the Department of Consumer and Business Services for the biennium beginning July 1, 2019, from revenues dedicated, continuously appropriated, appropriated or otherwise made available for the purpose of administering and enforcing the duties, functions and powers transferred by section 1 of this 2021 Act are transferred to and are available for expenditure by the Oregon Health Authority for the biennium beginning July 1, 2021, for the purpose of administering and enforcing the duties, functions and powers transferred by section 1 of this 2021 Act.

(2) The expenditure classifications, if any, established by Acts authorizing or limiting expenditures by the department remain applicable to expenditures by the authority under this section.

ACTION, PROCEEDING, PROSECUTION

SECTION 4. The transfer of duties, functions and powers to the Oregon Health Authority by section 1 of this 2021 Act does not affect any action, proceeding or prosecution involving or with respect to the duties, functions and powers begun before and pending at the time of the transfer, except that the authority is substituted for the Department of Consumer and Business Services in the action, proceeding or prosecution.

LIABILITY, DUTY, OBLIGATION

SECTION 5. (1) Nothing in sections 1 to 39 of this 2021 Act relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions and powers transferred by section 1 of this 2021 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 Department of Consumer and Business Services legally incurred under contracts, leases and business transactions executed, entered into or begun before the operative date of section 1 of this 2021 Act accruing under or with respect to the duties, functions and powers transferred by section 1 of this 2021 Act are transferred to the authority. For the purpose of succession to these rights and obligations, the authority is a continuation of the department and not a new authority.

RULES

SECTION 6. Notwithstanding the transfer of duties, functions and powers by section 1 of this 2021 Act, the rules of the Department of Consumer and Business Services with respect to such duties, functions or powers that are in effect on the operative date of section 1 of this 2021 Act continue in effect until superseded or repealed by rules of the Oregon Health Authority. References in the rules of the department to the department or an officer

or employee of the department are considered to be references to the authority or an officer or employee of the authority.

SECTION 7. Whenever, in any uncodified law or resolution of the Legislative Assembly or in any rule, document, record or proceeding authorized by the Legislative Assembly, in the context of the duties, functions and powers transferred by section 1 of this 2021 Act, reference is made to the Department of Consumer and Business Services, or an officer or employee of the department, whose duties, functions or powers are transferred by section 1 of this 2021 Act, the reference is considered to be a reference to the Oregon Health Authority or an officer or employee of the authority who by this 2021 Act is charged with carrying out the duties, functions and powers.

REPORT TO LEGISLATIVE ASSEMBLY

SECTION 8. No later than January 1, 2022, and every 12 months thereafter, the Oregon Health Authority shall report to the interim committees of the Legislative Assembly related to health, in the manner provided in ORS 192.245, on the progress of integrating the duties, functions and powers transferred from the Department of Consumer and Business Services to the authority under section 1 of this 2021 Act.

COFA PREMIUM ASSISTANCE PROGRAM

SECTION 9. ORS 735.601 is amended to read:

735.601. ORS 735.601 to 735.617 establish the COFA Premium Assistance Program to be administered by the [*Department of Consumer and Business Services*] **Oregon Health Authority**. The purpose of the program is to provide financial assistance to enable low-income citizens of the island nations in the Compact of Free Association who are residing in Oregon to purchase qualified health plan coverage through the health insurance exchange and to pay out-of-pocket costs associated with the coverage.

SECTION 10. ORS 735.608 is amended to read:

735.608. (1) An individual is eligible for the COFA Premium Assistance Program if the individual:

(a) Is a resident;

(b) Is a COFA citizen;

(c) Enrolls in a qualified health plan;

(d) Has income that is less than 138 percent of the federal poverty guidelines; and

(e) Qualifies for an advance premium tax credit toward the cost of the individual's qualified health plan.

(2) Within the limits of moneys in the COFA Premium Assistance Program Fund, the [*Department of Consumer and Business Services*] **Oregon Health Authority** shall pay the premium cost for a qualified health plan and the out-of-pocket costs for the coverage provided by the plan for an individual who meets the criteria in subsection (1) of this section.

(3) The [*department*] **authority** may disenroll a participant from the program if the participant:

(a) No longer meets the eligibility criteria specified in subsection (1) of this section;

(b) Fails, without good cause, to comply with procedural or documentation requirements established by the [*department*] **authority** in accordance with subsection (4) of this section;

(c) Fails, without good cause, to notify the [*department*] **authority** of a change of address in a

timely manner;

(d) Withdraws the participant's application or requests termination of coverage; or

(e) Performs an act, practice or omission that constitutes fraud and, as a result, an insurer rescinds the participant's policy for the qualified health plan.

(4) The [*department*] **authority** shall establish:

(a) Application, enrollment and renewal processes for the COFA Premium Assistance Program;

(b) The qualified health plans that are eligible for reimbursement under the program;

(c) Procedural requirements for continued participation in the program, including participant documentation requirements that are necessary for the [*department*] **authority** to administer the program;

(d) Open enrollment periods and special enrollment periods consistent with the enrollment periods for the health insurance exchange; and

(e) A comprehensive community education and outreach campaign, working with stakeholder and community organizations, to facilitate applications for, and enrollment in, the program.

SECTION 11. ORS 735.617 is amended to read:

735.617. The COFA Premium Assistance Program Fund is established in the State Treasury, separate and distinct from the General Fund. Moneys in the COFA Premium Assistance Program Fund are continuously appropriated to the [*Department of Consumer and Business Services*] **Oregon Health Authority** for the payment of premium costs and out-of-pocket costs through the COFA Premium Assistance Program and the costs of the [*department*] **authority** in administering the program. Interest earned by the fund shall be credited to the fund.

SECTION 12. ORS 414.025 is amended to read:

414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially applicable statutory definition requires otherwise:

(1)(a) "Alternative payment methodology" means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services.

(b) "Alternative payment methodology" includes, but is not limited to:

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

(2) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

(3) "Behavioral health clinician" means:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

(c) A licensed nurse practitioner with a specialty in psychiatric mental health;

(d) A licensed clinical social worker;

(e) A licensed professional counselor or licensed marriage and family therapist;

(f) A certified clinical social work associate;

(g) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

(h) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

(4) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability

or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

(5) "Behavioral health home" means a mental health disorder or substance use disorder treatment organization, as defined by the Oregon Health Authority by rule, that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders.

(6) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security Income payments.

(7) "Community health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services such as first aid or blood pressure screening.

(8) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.572.

(9) "Dually eligible for Medicare and Medicaid" means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

(a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or

(b) Enrolled in Part B of Title XVIII of the Social Security Act.

(10)(a) "Family support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides supportive services to and has experience parenting a child who:

(A) Is a current or former consumer of mental health or addiction treatment; or

(B) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "family support specialist" may be a peer wellness specialist or a peer support specialist.

(11) "Global budget" means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

(12) "Health insurance exchange" or "exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(13) "Health services" means at least so much of each of the following as are funded by the Legislative Assembly based upon the prioritized list of health services compiled by the Health Evi-

dence Review Commission under ORS 414.690:

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

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

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

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

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

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

(15)(a) "Integrated health care" means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:

(A) Mental illness.

(B) Substance use disorders.

(C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.

(E) Developmental risks and conditions.

(F) Stress-related physical symptoms.

(G) Preventive care.

(H) Ineffective patterns of health care utilization.

(b) As used in this subsection, "other care team members" includes but is not limited to:

(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;

(B) Peer wellness specialists;

(C) Peer support specialists;

(D) Community health workers who have completed a state-certified training program;

(E) Personal health navigators; or

(F) Other qualified individuals approved by the Oregon Health Authority.

(16) "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 or the authority may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(17) "Medical assistance" means so much of the medical, mental health, preventive, supportive,

palliative and remedial care and services as may be prescribed by the authority according to the standards established pursuant to ORS 414.065, including premium assistance [*and*] **under ORS 414.115, 414.117 and 735.601 to 735.617,** payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of health services and for services described in ORS 414.710.

(18) "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. Except as provided in ORS 411.439 and 411.447, "medical assistance" does not include care or services for a resident of a nonmedical public institution.

(19) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS 414.655 and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

(20) "Peer support specialist" means any of the following individuals who meet qualification criteria adopted by the authority under ORS 414.665 and who provide supportive services to a current or former consumer of mental health or addiction treatment:

(a) An individual who is a current or former consumer of mental health treatment; or

(b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from an addiction disorder.

(21) "Peer wellness specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

(22) "Person centered care" means care that:

(a) Reflects the individual patient's strengths and preferences;

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

(c) Is based upon the patient's goals and will assist the patient in achieving the goals.

(23) "Personal health navigator" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

(24) "Prepaid managed care health services organization" means a managed dental care, mental health or chemical dependency organization that contracts with the authority under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to

medical assistance recipients.

(25) "Quality measure" means the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 414.638.

(26) "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.

(27)(a) "Youth support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

(A) Is not older than 30 years of age; and

(B)(i) Is a current or former consumer of mental health or addiction treatment; or

(ii) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "youth support specialist" may be a peer wellness specialist or a peer support specialist.

HEALTH INSURANCE EXCHANGE

SECTION 13. ORS 243.142 is amended to read:

243.142. The [*Department of Consumer and Business Services*] **Oregon Health Authority** shall apply for a waiver of federal law or any formal permission from the appropriate federal agency or agencies that is necessary to allow districts and eligible employees of districts to obtain health benefit plans through the health insurance exchange in accordance with ORS 243.886.

SECTION 14. ORS 411.400 is amended to read:

411.400. (1) An application for any category of aid shall also constitute an application for medical assistance.

(2) [*Except as provided in subsection (6) of this section,*] The Department of Human Services and the Oregon Health Authority shall accept an application for medical assistance and any required verification of eligibility from the applicant, an adult who is in the applicant's household or family, an authorized representative of the applicant or, if the applicant is a minor or incapacitated, someone acting on behalf of the applicant:

(a) Over the Internet;

(b) By telephone;

(c) By mail;

(d) In person; and

(e) Through other commonly available electronic means.

(3) The department and the authority may require an applicant or person acting on behalf of an applicant to provide only the information necessary for the purpose of making an eligibility determination or for a purpose directly connected to the administration of medical assistance or the health insurance exchange.

(4) The department and the authority shall provide application and recertification assistance to individuals with disabilities, individuals with limited English proficiency, individuals facing physical or geographic barriers and individuals seeking help with the application for medical assistance or recertification of eligibility for medical assistance:

(a) Over the Internet;

(b) By telephone; and

(c) In person.

(5)(a) The department [*of Human Services and the authority*] shall promptly transfer information received under this section to the [*Department of Consumer and Business Services, the United States Department of Health and Human Services or the Internal Revenue Service*] **authority** as necessary for the determination of eligibility for the health insurance exchange, premium tax credits or cost-sharing reductions.

(b) The department [*of Human Services*] shall promptly transfer information received under this section to the authority for individuals who are eligible for medical assistance because they qualify for public assistance.

[*(6) The Department of Human Services and the authority shall accept from the Department of Consumer and Business Services an application and any verification that was submitted to the Department of Consumer and Business Services by an applicant or on behalf of an applicant in order for the Department of Human Services or the authority to determine the applicant's eligibility for medical assistance.*]

SECTION 15. ORS 411.402 is amended to read:

411.402. (1) The Department of Human Services and the Oregon Health Authority shall adopt by rule, consistent with federal requirements, the procedures for verifying eligibility for medical assistance, including but not limited to all of the following:

(a) The department and the authority shall access all relevant state and federal electronic databases for any eligibility information available through the databases.

(b) The department and the authority shall verify the following factors through self-attestation:

(A) Pregnancy;

(B) Date of birth;

(C) Household composition; and

(D) Residency.

(c) The department and the authority may not use self-attestation to verify citizenship and immigration status.

(d) The department and the authority may require the applicant to provide verification in addition to the verification specified in this subsection only if the department and the authority are unable to obtain the information electronically or if the information obtained electronically is not reasonably compatible with information provided by or on behalf of the applicant.

(e) The department and the authority shall use methods of administration that are in the best interests of applicants and recipients and that are necessary for the proper and efficient operation of the medical assistance program.

(2) Information obtained by the department [*or the authority*] under this section may be [*exchanged*] **shared** with the [*health insurance exchange*] **authority** and with other state or federal agencies for the purpose of:

(a) Verifying eligibility for medical assistance, participation in the exchange or other health benefit programs;

(b) Establishing the amount of any tax credit due to the person, cost-sharing reduction or premium assistance;

(c) Improving the provision of services; and

(d) Administering health benefit programs.

SECTION 16. ORS 411.406 is amended to read:

411.406. (1) A medical assistance recipient shall immediately notify the Department of Human Services or the Oregon Health Authority, if required, of the receipt or possession of property or income or other change in circumstances that directly affects the eligibility of the recipient to receive medical assistance, or that directly affects the amount of medical assistance for which the recipient is eligible. Failure to give the notice shall entitle the department or the authority to recover from the recipient the amount of assistance improperly disbursed by reason thereof.

(2)(a) The department or the authority shall redetermine the eligibility of a medical assistance recipient at intervals specified by federal law.

(b) The department and the authority shall redetermine eligibility under this subsection on the basis of information available to the department and the authority and may not require the recipient to provide information if the department or the authority is able to determine eligibility based on information in the recipient's record or through other information that is available to the department or the authority.

(3) Notwithstanding subsection (2) of this section, if the department or the authority receives information about a change in a medical assistance recipient's circumstances that may affect eligibility for medical assistance, the department or the authority shall promptly redetermine eligibility.

(4) If the department or the authority determines that a medical assistance recipient no longer qualifies for the medical assistance program in which the recipient is enrolled, the department or the authority must determine eligibility for other medical assistance programs, potential eligibility for the health insurance exchange, premium tax credits and cost-sharing reductions before terminating the recipient's medical assistance.

(5) If [*the*] **a** recipient **of medical assistance administered by the department** appears to qualify for the exchange, premium tax credits or cost-sharing reductions, the department [*or the authority*] shall promptly transfer the recipient's record to the [*exchange*] **authority** to process those benefits.

SECTION 17. 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**, except as provided in ORS 741.004,** all of the authority's departmental divisions.

(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) Publish health outcome and quality measure data collected by the Oregon Health Authority at aggregate levels that do not disclose information otherwise protected by law. The information published must report, for each coordinated care organization and each health benefit plan sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board:

(A) Quality measures;

(B) Costs;

(C) Health outcomes; and

(D) Other information that is necessary for members of the public to evaluate the value of health services delivered by each coordinated care organization and by each health benefit plan.

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

(f) Approve and monitor community-centered health initiatives described in ORS 413.032 (1)(h) 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) Establish cost containment mechanisms to reduce health care costs.

(h) 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) 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 741.340 to be used as the baseline for all health benefit plans offered through the health insurance exchange.

(k) Investigate and report annually to the Legislative Assembly 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.

(L) 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.

(m) 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.

(n) 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.

(o) Work with the Health Information Technology Oversight Council to foster health information technology systems and practices that promote the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.570 and align health information technology systems and practices across this state.

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

(a) Subject to the approval of the Governor, organize and reorganize the authority as the 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 413.042 and 741.340 without federal approval, the authority is authorized

to request, in accordance with ORS 413.072, waivers or other approval necessary to perform those duties. The authority 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 413.042 and 741.340 and by other statutes.

(5) The board shall consult with the Department of Consumer and Business Services in completing the tasks set forth in subsection (1)(j) and (k)(A) of this section.

SECTION 18. 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;

(b) Administer the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.570;

(c) Administer the Oregon Prescription Drug Program;

(d) Develop the policies for and the provision of publicly funded medical care and medical assistance in this state;

(e) Develop the policies for and the provision of mental health treatment and treatment of addictions;

(f) Assess, promote and protect the health of the public as specified by state and federal law;

(g) Provide regular reports to the 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;

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

(i) 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;

(j) 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;

(k) 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;

(L) 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;

(m) Develop, in consultation with the Department of Consumer and Business Services, one or more products designed to provide more affordable options for the small group market;

(n) Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4); and

(o) Implement a process for collecting the health outcome and quality measure data identified by the Health Plan Quality Metrics Committee and report the data to the Oregon Health Policy

1 Board.
2 (2) The Oregon Health Authority is authorized to:
3 (a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate
4 health care reform in Oregon and to provide comparative cost and quality information to consumers,
5 providers and purchasers of health care about Oregon's health care systems and health plan net-
6 works in order to provide comparative information to consumers.
7 (b) Develop uniform contracting standards for the purchase of health care, including the fol-
8 lowing:
9 (A) Uniform quality standards and performance measures;
10 (B) Evidence-based guidelines for major chronic disease management and health care services
11 with unexplained variations in frequency or cost;
12 (C) Evidence-based effectiveness guidelines for select new technologies and medical equipment;
13 (D) A statewide drug formulary that may be used by publicly funded health benefit plans; and
14 (E) Standards that accept and consider tribal-based practices for mental health and substance
15 abuse prevention, counseling and treatment for persons who are Native American or Alaska Native
16 as equivalent to evidence-based practices.
17 (3) The enumeration of duties, functions and powers in this section is not intended to be exclu-
18 sive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Au-
19 thority by ORS 413.006 to 413.042, 415.012 to 415.430 and [*741.340*] **735.601 to 735.617, 741.001 to**
20 **741.540, 741.802 and 741.900** or by other statutes.
21 **SECTION 19.** ORS 741.002 is amended to read:
22 741.002. (1) The duties of the [*Department of Consumer and Business Services*] **Oregon Health**
23 **Authority** include:
24 (a) Administering a health insurance exchange in accordance with federal law to make qualified
25 health plans available to individuals and groups throughout this state.
26 (b) Providing information in writing, through an Internet-based clearinghouse and through a
27 toll-free telephone line, that will assist individuals and small businesses in making informed health
28 insurance decisions and that may include:
29 (A) The rating assigned to each health plan and the rating criteria that were used;
30 (B) Quality and enrollee satisfaction survey results; and
31 (C) The comparative costs, benefits, provider networks of health plans and other useful infor-
32 mation.
33 (c) Establishing and maintaining an [*electronic calculator that allows individuals and employers*
34 *to determine the cost of coverage after deducting any applicable tax credits or cost-sharing reduction*]
35 **information technology platform through which individuals can compare, shop for and pur-**
36 **chase qualified health plans**.
37 (d) Operating a call center [*for answers to*] **dedicated to answering** questions from individuals
38 seeking enrollment in a qualified health plan [*or in the state medical assistance program*].
39 [*(e) Providing information about the eligibility requirements and the application processes for the*
40 *state medical assistance program.*]
41 (2) The [*department*] **authority** shall:
42 (a) Screen, certify and recertify health plans as qualified health plans according to the require-
43 ments, standards and criteria adopted by the [*department*] **authority** under ORS 741.310 and ensure
44 that qualified health plans provide choices of coverage.
45 (b) Decertify or suspend, in accordance with ORS chapter 183, the certification of a health plan

1 that fails to meet federal and state standards in order to exclude the health plan from participation
2 in the exchange.
3 (c) Promote fair competition of carriers participating in the exchange by certifying multiple
4 health plans as qualified under ORS 741.310.
5 (d) Assign ratings to health plans in accordance with criteria established by the United States
6 Secretary of Health and Human Services and by the [*department*] **authority**.
7 (e) Establish open and special enrollment periods for all enrollees, and monthly enrollment pe-
8 riods for Native Americans [*in accordance*] **that are consistent** with federal law.
9 (f) Assist individuals and groups to enroll in qualified health plans, including defined contribu-
10 tion plans as defined in section 414 of the Internal Revenue Code and, if appropriate, collect and
11 remit premiums for such individuals or groups.
12 (g) Facilitate community-based assistance with enrollment in qualified health plans by awarding
13 grants to entities that are certified as navigators as described in 42 U.S.C. 18031(i).
14 (h) Provide employers with the names of employees who end coverage under a qualified health
15 plan during a plan year.
16 (i) Certify the eligibility of an individual for an exemption from the individual responsibility re-
17 quirement of section 5000A of the Internal Revenue Code.
18 (j) Provide information to the federal government necessary for individuals who are enrolled in
19 qualified health plans through the exchange to receive tax credits and reduced cost-sharing.
20 (k) Provide to the federal government any information necessary to comply with federal re-
21 quirements including:
22 (A) Information regarding individuals determined to be exempt from the individual responsibility
23 requirement of section 5000A of the Internal Revenue Code;
24 (B) Information regarding employees who have reported a change in employer; and
25 (C) Information regarding individuals who have ended coverage during a plan year.
26 (L) Take any other actions necessary and appropriate to comply with the federal requirements
27 for a health insurance exchange.
28 (m) Work in coordination with the [*Oregon Health Authority and the*] Oregon Health Policy
29 Board in carrying out its duties.
30 (3) The [*department*] **authority** may adopt rules necessary to carry out its duties and functions
31 under ORS 741.001 to 741.540.
32 (4) The [*department*] **authority** may contract or enter into an intergovernmental agreement with
33 the federal government to perform any of the duties and functions described in ORS 741.001 to
34 741.540.
35 [*(5) The department may assign contracts to the Oregon Health Authority if necessary for the au-*
36 *thority to administer the state medical assistance program.*]
37 **SECTION 20.** ORS 741.003 is amended to read:
38 741.003. (1) The health insurance exchange is under the supervision of the Director of the [*De-*
39 *partment of Consumer and Business Services*] **Oregon Health Authority**.
40 (2) The director has such powers as are necessary to carry out ORS 741.001 to 741.540.
41 (3) The director may employ, supervise and terminate the employment of such staff as the di-
42 rector deems necessary. The director shall prescribe their duties and fix their compensation. [*An*
43 *employee of the department, other than the director, who has management responsibilities or decision-*
44 *making authority with respect to the administration of the health insurance exchange may not also have*
45 *management responsibilities or decision-making authority with respect to reviewing rates, assessing*

provider network adequacy, approving forms, determining financial solvency or enforcing other legal requirements applicable to insurers offering health insurance, as defined in ORS 731.162, in this state.] Employees administering the exchange may not be individuals who are:

(a) Employed by, consultants to or members of a board of directors of:

(A) An insurer**,** [*or*] third party administrator **or pharmacy benefit manager, as defined in ORS 735.530**;

(B) An insurance producer; or

(C) A health care provider, health care facility**,** [*or*] health clinic**, pharmacy, pharmacy benefit advisor, prescription drug manufacturer or drug outlet, as that term is defined in ORS 689.005**;

(b) Members, board members or employees of a trade association of:

(A) Insurers**,** [*or*] third party administrators **or pharmacy benefit managers**; or

(B) Health care providers, health care facilities**,** [*or*] health clinics**, pharmacies, pharmacy benefit managers, drug manufacturers or drug outlets**; or

(c) Health care providers, unless they receive no compensation for rendering services as health care providers and do not have ownership interests in professional health care practices.

SECTION 21. ORS 741.004 is amended to read:

741.004. (1) The Health Insurance Exchange Advisory Committee is created to advise the Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** in the development and implementation of the policies and operational procedures governing the administration of a health insurance exchange in this state including, but not limited to, all of the following:

(a) The amount of the assessment imposed on insurers under ORS 741.105.

(b) The implementation of a Small Business Health Options Program in accordance with 42 U.S.C. 18031.

(c) The processes and procedures to enable each insurance producer to be authorized to act for all of the insurers offering **qualified** health [*benefit*] plans through the health insurance exchange.

(d) The affordability of **qualified** health [*benefit*] plans offered by employers under section 5000A(e)(1) of the Internal Revenue Code.

(e) Outreach strategies for reaching minority and low-income communities.

(f) Solicitation of customer feedback.

(g) The affordability of **qualified** health [*benefit*] plans offered through the exchange.

(2) The committee consists of 15 members. Thirteen members shall be appointed by the Governor and are subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565. The appointed members serve at the pleasure of the Governor. The Director of the Department of Consumer and Business Services **or the director's designee** and the Director of the Oregon Health Authority **or the director's designee** shall serve as ex officio members of the committee.

(3) The 13 members appointed by the Governor must represent the interests of:

(a) Insurers;

(b) Insurance producers;

(c) Navigators, in-person assisters, application counselors and other individuals with experience in facilitating enrollment in qualified health plans;

(d) Health care providers;

(e) The business community, including small businesses and self-employed individuals;

(f) Consumer advocacy groups, including advocates for enrolling hard-to-reach populations;

(g) Enrollees in **qualified** health [*benefit*] plans; and

(h) State agencies that administer the medical assistance program under ORS chapter 414.

(4) The Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** may solicit recommendations from the committee and the committee may initiate recommendations on its own.

(5) The committee [*shall*] **may** provide annual reports to the Legislative Assembly, in the manner provided in ORS 192.245, of the findings and recommendations the committee considers appropriate, including **but not limited to** a report on the:

(a) Adequacy of assessments for reserve programs and administrative costs;

(b) Implementation of the Small Business Health Options Program;

(c) Number of qualified health plans offered through the exchange;

(d) Number and demographics of individuals enrolled in qualified health plans;

(e) Advance premium tax credits provided to enrollees in qualified health plans; and

(f) Feedback from the community about satisfaction with the operation of the exchange and qualified health plans offered through the exchange.

(6) The members of the committee shall be appointed for a term [*of*] **fixed by the Governor, not to exceed** two years**,** and shall serve without compensation, but shall be entitled to travel expenses in accordance with ORS 292.495. The committee may hire, subject to the approval of the director [*of the Department of Consumer and Business Services*], such experts as the committee may require to discharge its duties. All expenses of the committee shall be paid out of the Health Insurance Exchange Fund established in ORS 741.102.

(7) The employees of the [*Department of Consumer and Business Services*] **Oregon Health Authority responsible for administering the health insurance exchange** are directed to assist the committee in the performance of its duties under subsection (1) of this section and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the committee consider necessary to perform their duties under subsection (1) of this section.

SECTION 22. ORS 741.008 is amended to read:

741.008. The [*Department of Consumer and Business Services*] **Oregon Health Authority** shall conduct a state or nationwide criminal records check under ORS 181A.195 on, and for that purpose may require the fingerprints of, a person who:

(1) Is employed by or applying for employment with the [*department*] **authority** in a position related to the administration of the health insurance exchange; or

(2) Is, or will be, providing services to the [*department*] **authority** in a position related to the administration of the health insurance exchange:

(a) In which the person is providing information technology services and has control over, or access to, information technology systems that would allow the person to harm the information technology systems or the information contained in the systems;

(b) In which the person has access to information that is confidential or for which state or federal laws, rules or regulations prohibit disclosure;

(c) That has payroll functions or in which the person has responsibility for receiving, receipting or depositing money or negotiable instruments, for billing, collections or other financial transactions or for purchasing or selling property or has access to property held in trust or to private property in the temporary custody of the [*department*] **authority**;

(d) That has mailroom duties as a primary duty or job function;

(e) In which the person has responsibility for auditing the [*department*] **authority**;

(f) That has personnel or human resources functions as a primary responsibility;

(g) In which the person has access to Social Security numbers, dates of birth or criminal background information; or

(h) In which the person has access to tax or financial information about individuals or business entities.

SECTION 23. ORS 741.102 is amended to read:

741.102. The Health Insurance Exchange Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Health Insurance Exchange Fund shall be credited to the fund. The Health Insurance Exchange Fund consists of moneys received by the [*Department of Consumer and Business Services*] **Oregon Health Authority** under ORS 741.001 to 741.540. Moneys in the fund are continuously appropriated to the [*department*] **authority** for carrying out the purposes of ORS 741.001 to 741.540.

SECTION 24. ORS 741.105 is amended to read:

741.105. (1) The [*Department of Consumer and Business Services*] **Oregon Health Authority** shall establish, by rule, an administrative charge. The [*department*] **authority** shall impose and collect the charge from all insurers and state programs participating in the health insurance exchange. The Health Insurance Exchange Advisory Committee shall advise the [*department*] **authority** in establishing the administrative charge. The charge must be in an amount sufficient to cover the costs of grants to navigators, in-person assisters and application counselors certified under ORS 741.002**,** [*and*] to pay the administrative and operational expenses of the [*department*] **authority** in carrying out ORS 741.001 to 741.540 **and to maintain an information technology platform through which individuals can compare, shop for and purchase qualified health plans**. The charge shall be paid in a manner and at intervals prescribed by the [*department*] **authority**.

(2)**(a)** Each insurer's charge**, except as provided in paragraph (b) of this subsection,** shall be based on the number of individuals, excluding individuals enrolled in state programs, who are enrolled in **qualified** health plans offered by the insurer through the exchange.

(b) Insurers offering dental only health plans certified by the authority and offered outside of the exchange shall be based on the number of enrollees in all of the dental only health plans certified by the authority.

(c) The [*assessment on*] **charge to** each state program shall be based on the number of individuals enrolled in state programs offered through the exchange.

(3) The charge **imposed under this section** may not exceed:

(a) Five percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is at or below 175,000;

(b) Four percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is above 175,000 and at or below 300,000; and

(c) Three percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is above 300,000.

[*(3)(a)*] **(4)(a)** If charges collected under subsection (1) of this section exceed the amounts needed for the administrative and operational expenses of the [*department*] **authority** in administering the health insurance exchange **and to maintain an information technology platform through which individuals can compare, shop for and purchase qualified health plans**, the excess moneys collected may be held and used by the [*department*] **authority** to offset future net losses.

(b) The maximum amount of excess moneys that may be held under this subsection is the total [*administrative and operational expenses of administering the health insurance exchange*] **costs and**

expenses described in subsection (1) of this section anticipated by the [*department*] **authority** for a six-month period. Any moneys received that exceed the maximum shall be applied by the [*department*] **authority** to reduce the charges imposed by this section.

[*(4)*] **(5)** Charges shall be based on annual statements and other reports submitted by insurers and state programs as prescribed by the [*department*] **authority**.

[*(5)*] **(6)** In addition to charges imposed under subsection (1) of this section, to the extent permitted by federal law the [*department*] **authority** may impose a fee on insurers and state programs participating in the exchange to cover the cost of commissions of insurance producers that are certified by the [*department*] **authority** or by the United States Department of Health and Human Services to facilitate the participation of individuals and employers in the exchange.

[*(6)(a)*] **(7)(a)** The [*Department of Consumer and Business Services*] **authority** shall establish and amend the charges and fees under this section in accordance with ORS 183.310 to 183.410.

(b) If the [*department*] **authority** intends to increase an administrative charge or fee, the notice of intended action required by ORS 183.335 shall be sent, if the Legislative Assembly is not in session, to the interim committees of the Legislative Assembly related to health, to the Joint Interim Committee on Ways and Means and to each member of the Legislative Assembly. The Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** shall appear at the next meetings of the interim committees of the Legislative Assembly related to health and the next meetings of the Joint Interim Committee on Ways and Means that occur after the notice of intended action is sent and fully explain the basis and rationale for the proposed increase in the administrative charges or fees.

(c) If the Legislative Assembly is in session, the [*department*] **authority** shall give the notice of intended action to the committees of the Legislative Assembly related to health and to the Joint Committee on Ways and Means and shall appear before the committees to fully explain the basis and rationale for the proposed increase in administrative charges or fees.

[*(7)*] **(8)** All charges and fees collected under this section shall be deposited in the Health Insurance Exchange Fund.

SECTION 25. ORS 741.107 is amended to read:

741.107. (1) As used in this section, "Small Business Health Options Program" has the meaning given that term in ORS 741.300.

(2) If the [*Department of Consumer and Business Services*] **Oregon Health Authority** submits a request to the Oregon Department of Administrative Services to procure an information technology product or service for creating an Internet portal for the Small Business Health Options Program and the anticipated cost exceeds $1 million:

(a) The [*department*] **authority** shall, if the Legislative Assembly is not in session, notify the interim committees of the Legislative Assembly related to health, the Joint Interim Committee on Ways and Means and each member of the Legislative Assembly. The Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** shall appear at the next meetings of the interim committees of the Legislative Assembly related to health and the next meetings of the Joint Interim Committee on Ways and Means to fully explain the need for the product or service.

(b) If the Legislative Assembly is in session, the [*department*] **authority** shall notify the committees of the Legislative Assembly related to health and the Joint Committee on Ways and Means and the director shall appear before the committees to fully explain the need for the product or service.

SECTION 26. ORS 741.220 is amended to read:

741.220. (1) The [*Department of Consumer and Business Services*] **Oregon Health Authority** shall keep an accurate accounting of the operation and all activities, receipts and expenditures of the [*department*] **authority** with respect to the health insurance exchange.

(2) The Secretary of State shall conduct an annual financial audit of the [*department's*] **authority's** revenues and expenditures in carrying out ORS 741.001 to 741.540. The audit shall include but is not limited to:

(a) A review of the sources and uses of the moneys in the Health Insurance Exchange Fund;

(b) A review of charges and fees imposed and collected pursuant to ORS 741.105; and

(c) A review of premiums collected and remitted.

(3) Every two years, the Secretary of State shall conduct a performance audit of the exchange.

(4) The Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** and employees of the [*department*] **authority responsible for administering the health insurance exchange** shall cooperate with the Secretary of State in the audits and reviews conducted under subsections (2) and (3) of this section.

(5) The audits shall be conducted using generally accepted accounting principles and any financial integrity requirements of federal authorities.

(6) The cost of the audits required by subsections (2) and (3) of this section shall be paid by the [*department*] **authority**.

(7) The Secretary of State shall issue a report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Oregon Health Authority, the Oregon Health Policy Board and appropriate federal authorities on the results of each audit conducted pursuant to this section, including any recommendations for corrective actions. The report shall be available for public inspection, in accordance with the Secretary of State's established rules and procedures governing public disclosure of audit documents.

(8) To the extent the audit requirements under this section are similar to any audit requirements imposed on the [*department*] **authority** by federal authorities, the Secretary of State and the [*department*] **authority** shall make reasonable efforts to coordinate with the federal authorities to promote efficiency and the best use of resources in the timing and provision of information.

(9) Not later than the 90th day after the Secretary of State completes and delivers an audit report issued under subsection (7) of this section, the director shall notify the Secretary of State in writing of the corrective actions taken or to be taken, if any, in response to any recommendations in the report. The Secretary of State may extend the 90-day period for good cause.

SECTION 27. ORS 741.222 is amended to read:

741.222. (1) The Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** shall report to the Legislative Assembly each year on:

(a) The financial condition of the health insurance exchange, including actual and projected revenues and expenses of the administrative operations of the exchange and commissions paid to insurance producers out of fees collected under ORS 741.105 [*(5)*] **(6)**;

[*(b) The implementation of the Small Business Health Options Program;*]

[*(c)*] **(b)** The [*development*] **implementation, functionality, costs and cost savings** of the information technology [*system*] **platform** for the exchange; and

[*(d)*] **(c)** Any other information requested by the leadership of the Legislative Assembly.

(2) The director shall provide to the Legislative Assembly, the Governor[*, the Oregon Health Authority*] and the Oregon Health Policy Board, not later than April 15 of each year:

(a) A report covering the activities and operations of the [*Department of Consumer and Business*

Services] **authority** in administering the health insurance exchange during the previous year of operations;

(b) A statement of the financial condition, as of December 31 of the previous year, of the Health Insurance Exchange Fund; **and**

[*(c) A description of the role of insurance producers in the exchange; and*]

[*(d)*] **(c)** Recommendations, if any, for additional groups to be eligible to purchase qualified health plans through the exchange under ORS 741.310.

SECTION 28. ORS 741.300 is amended to read:

741.300. As used in ORS 741.001 to 741.540:

(1) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(2) "Essential health benefits" has the meaning given that term in ORS 731.097.

(3) "Health benefit plan" has the meaning given that term in ORS 743B.005.

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

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

(6) "Health insurance exchange" or "exchange" means **the division of the Oregon Health Authority that operates** an American Health Benefit Exchange as described in 42 U.S.C. 18031, 18032, 18033 and 18041 **and the information technology platform through which individuals can compare, shop for and purchase qualified health plans**.

(7) "Health plan" means [*health insurance,*] a health benefit plan or [*health care coverage*] **dental only benefit plan** offered by an insurer.

(8) "Insurer" means an insurer as defined in ORS 731.106 that offers health insurance **or dental only health plans**, a health care service contractor, a prepaid managed care health services organization or a coordinated care organization.

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

(10) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025.

(11) "State program" means a program providing medical assistance, as defined in ORS 414.025, and any self-insured health benefit plan or health plan offered to employees by the Public Employees' Benefit Board or the Oregon Educators Benefit Board.

(12) "Qualified health plan" means a health [*benefit*] plan available for purchase through the health insurance exchange.

(13) "Small Business Health Options Program" or "SHOP" means a health insurance exchange for small employers as described in 42 U.S.C. 18031.

SECTION 29. ORS 741.310 is amended to read:

741.310. (1)(a) Individuals and families may purchase qualified health plans through the health insurance exchange.

(b) The following groups may purchase qualified health plans through the Small Business Health Options Program:

(A) Employers with no more than [*100*] **50** employees; and

(B) 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 **qualified** 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.

1 (b) Only employers that **are approved to participate in the SHOP and that** purchase **small**
2 **group qualified** health plans through the SHOP may be eligible to receive small employer health
3 insurance credits under section 45R of the Internal Revenue Code.
4 (3) Only an insurer that has a certificate of authority to transact insurance in this state and
5 that meets applicable **state and** federal requirements for participating in the exchange may offer a
6 qualified health plan through the exchange. Any qualified health plan must be certified under ORS
7 741.002. Coordinated care organizations that do not have a certificate of authority to transact in-
8 surance may serve only medical assistance recipients through the exchange and may not offer
9 qualified health plans.
10 (4)(a) The [*Department of Consumer and Business Services*] **Oregon Health Authority** shall
11 adopt by rule uniform requirements, standards and criteria for the certification of qualified health
12 plans, including requirements that a qualified health plan provide, at a minimum, essential health
13 benefits and have acceptable consumer and provider satisfaction ratings.
14 (b) The [*department*] **authority** may limit the number of qualified health plans that may be of-
15 fered through the exchange as long as the same limit applies to all insurers.
16 (5) The [*department*] **authority** shall certify as qualified a dental only health plan as permitted
17 by federal law.
18 (6) The [*department*] **authority**, in collaboration with the [*Oregon Health Authority and the*] De-
19 partment of Human Services, shall coordinate the application and enrollment processes for the ex-
20 change and the state medical assistance program.
21 (7) The [*Department of Consumer and Business Services*] **authority** may establish risk mediation
22 programs within the exchange.
23 (8) The [*department*] **authority** shall establish by rule a process for certifying insurance pro-
24 ducers to facilitate the transaction of insurance through the exchange, in accordance with federal
25 standards and policies.
26 [*(9) The department shall ensure that an insurer charges the same premiums for plans sold through*
27 *the exchange as for identical plans sold outside of the exchange.*]
28 [*(10)*] **(9)** The [*department*] **authority** is authorized to enter into contracts for the performance
29 of the [*department's*] **authority's** duties, functions or operations with respect to the exchange, in-
30 cluding but not limited to contracting with:
31 (a) Insurers that meet the requirements of subsections (3) and (4) of this section, to offer quali-
32 fied health plans through the exchange; and
33 (b) Navigators, in-person assisters and application counselors certified by the [*department*] **au-**
34 **thority** under ORS 741.002.
35 [*(11)(a)*]**(10)(a)** The [*department*] **authority** shall consult with stakeholders, including but not
36 limited to representatives of school administrators, school board members, school employees and the
37 Oregon Educators Benefit Board, regarding the plans that may be offered through the exchange to
38 districts and eligible employees of districts under subsection (1)(b)(B) of this section and the insurers
39 that may offer the plans.
40 (b) The board and the [*department*] **authority** shall each adopt rules to ensure that:
41 (A) Any plan offered under subsection (1)(b)(B) of this section is underwritten by an insurer us-
42 ing a single risk pool composed of all eligible employees who are enrolled or who will be enrolled
43 in the plan both through the exchange and by the board; and
44 (B) In every plan offered under subsection (1)(b)(B) of this section, the coverage is comparable
45 to plans offered by the board.

1 [*(12)*] **(11)** The [*department*] **authority** is authorized to apply for and accept federal grants, other
2 federal funds and grants from nongovernmental organizations for purposes of developing, imple-
3 menting and administering the exchange. Moneys received under this subsection shall be deposited
4 in the Health Insurance Exchange Fund.
5 **SECTION 30.** ORS 741.390 is amended to read:
6 741.390. A person may not file or cause to be filed with the [*Department of Consumer and Busi-*
7 *ness Services*] **Oregon Health Authority** any article, certificate, report, statement, application or
8 any other information related to the health insurance exchange required or permitted by the [*de-*
9 *partment*] **authority** to be filed, that is known by the person to be false or misleading in any mate-
10 rial respect.
11 **SECTION 31.** ORS 741.400 is amended to read:
12 741.400. (1) The [*Department of Consumer and Business Services*] **Oregon Health Authority** may
13 serve by regular mail or, if requested by the recipient, by electronic mail a notice described in ORS
14 183.415 of the [*department's*] **authority's** determination of:
15 (a) A person's eligibility to purchase or to continue to purchase a qualified health plan through
16 the health insurance exchange;
17 (b) A person's eligibility for a premium tax credit for purchasing a qualified health plan or the
18 amount of the person's premium tax credit; or
19 (c) A person's eligibility for cost-sharing reductions for qualified health plans and the amount
20 of the person's cost-sharing reduction.
21 (2) The legal presumption described in ORS 40.135 (1)(q) does not apply to a notice that is served
22 by regular or electronic mail in accordance with subsection (1) of this section.
23 (3) Except as provided in subsection (4) of this section, a contested case notice served in ac-
24 cordance with subsection (1) of this section that complies with ORS 183.415 but for service by reg-
25 ular or electronic mail becomes a final order against a party and is not subject to ORS 183.470 (2),
26 upon the earlier of the following:
27 (a) If the party fails to request a hearing, the day after the date prescribed in the notice as the
28 deadline for requesting a hearing.
29 (b) The date the [*department*] **authority** or the Office of Administrative Hearings mails an order
30 dismissing a hearing request because:
31 (A) The party withdraws the request for hearing; or
32 (B) Neither the party nor the party's representative appears on the date and at the time set for
33 hearing.
34 (4) The [*department*] **authority** shall prescribe by rule a period of not less than 60 days after a
35 notice becomes a final order under subsection (3) of this section within which a party may request
36 a hearing under this subsection. If a party requests a hearing within the period prescribed under
37 this subsection, the [*department*] **authority** shall do one of the following:
38 (a) If the [*department*] **authority** finds that the party did not receive the written notice and did
39 not have actual knowledge of the notice, refer the request for hearing to the Office of Administra-
40 tive Hearings for a contested case proceeding on the merits of the [*department's*] **authority's** in-
41 tended action described in the notice.
42 (b) Refer the request for hearing to the Office of Administrative Hearings for a contested case
43 proceeding to determine whether the party received the written notice or had actual knowledge of
44 the notice. The [*department*] **authority** must show that the party had actual knowledge of the notice
45 or that the [*department*] **authority** mailed the notice to the party's correct address or sent an elec-

tronic notice to the party's correct electronic mail address.

(5) If a party informs the [*department*] **authority** that the party did not receive a notice served by regular or electronic mail in accordance with subsection (1) of this section, the [*department*] **authority** shall advise the party of the right to request a hearing under subsection (4) of this section.

SECTION 32. ORS 741.500 is amended to read:

741.500. (1)(a) The [*Department of Consumer and Business Services*] **Oregon Health Authority** shall adopt by rule the information that must be documented in order for a person to qualify for:

(A) **Qualified** health plan coverage through the health insurance exchange;

(B) Premium tax credits; and

(C) Cost-sharing reductions.

(b) The documentation specified by the [*department*] **authority** under this subsection shall include but is not limited to documentation of:

(A) The identity of the person;

(B) The status of the person as a United States citizen, or lawfully admitted noncitizen, and a resident of this state;

(C) Information concerning the income and resources of the person as necessary to establish the person's financial eligibility for coverage, for premium tax credits and for cost-sharing reductions, which may include income tax return information and a Social Security number; and

(D) Employer identification information and employer-sponsored health insurance coverage information applicable to the person.

(2) The [*department*] **authority** shall adopt by rule the information that must be documented in order to determine whether the person is exempt from a requirement to purchase or be enrolled in a health plan under section 5000A of the Internal Revenue Code or other federal law.

(3) The [*department*] **authority** shall implement systems that provide electronic access to, and use, disclosure and validation of data needed to administer the exchange, to comply with federal data access and data exchange requirements and to streamline and simplify exchange processes.

(4) Information and data that the [*department*] **authority** obtains under this section may be exchanged with other state or federal health insurance exchanges, with state or federal agencies and, subject to ORS 741.510, for the purpose of carrying out exchange responsibilities, including but not limited to:

(a) Establishing and verifying eligibility for:

(A) A state medical assistance program;

(B) The purchase of **qualified** health plans through the exchange; and

(C) Any other programs that are offered through the exchange;

(b) Establishing and verifying the amount of a person's federal tax credit, cost-sharing reduction or premium assistance;

(c) Establishing and verifying eligibility for exemption from the requirement to purchase or be enrolled in a health plan under section 5000A of the Internal Revenue Code or other federal law;

(d) Complying with other federal requirements; or

(e) Improving the operations of the exchange and for program analysis.

SECTION 33. ORS 741.510 is amended to read:

741.510. (1) Except as provided in subsection (3) of this section, documents, materials or other information that is in the possession or control of the [*Department of Consumer and Business Services*] **Oregon Health Authority** for the purpose of carrying out ORS 741.002, 741.310 and 741.500

or complying with federal health insurance exchange requirements, and that is protected from disclosure by state or federal law, remains confidential and is not subject to disclosure under ORS 192.311 to 192.478 or subject to subpoena or discovery or admissible into evidence in any private civil action in which the [*department*] **authority** is not a named party. The [*department*] **authority** may use confidential documents, materials or other information without further disclosure in order to carry out the duties described in ORS 741.002, 741.310 and 741.500 or to take any legal or regulatory action authorized by law.

(2) Documents, materials and other information to which subsection (1) of this section applies is subject to the public officer privilege described in ORS 40.270.

(3) The Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** may:

(a) Authorize the sharing of confidential documents, materials or other information that is subject to subsection (1) of this section within the [*department*] **authority** and subject to any conditions on further disclosure, for the purpose of carrying out the duties and functions of the [*department*] **authority** under ORS 741.002, 741.310 and 741.500 or complying with federal health insurance exchange requirements.

(b) Authorize the sharing of confidential documents, materials or other information that is subject to subsection (1) of this section or that is otherwise confidential under ORS 192.345 or 192.355 with other state or federal health insurance exchanges or regulatory authorities, the [*Oregon Health Authority,*] **Department of Consumer and Business Services,** the Department of Revenue, law enforcement agencies and federal authorities, if required or authorized by state or federal law and if the recipient agrees to maintain the confidentiality of the documents, materials or other information.

(c) Receive documents, materials or other information, including documents, materials or other information that is otherwise confidential, from other state or federal health insurance exchanges or regulatory authorities, the [*Oregon Health Authority*] **Department of Consumer and Business Services**, the Department of Revenue, law enforcement agencies or federal authorities. The [*Department of Consumer and Business Services*] **authority** shall maintain the confidentiality requested by the sender of the documents, materials or other information received under this section as necessary to comply with the laws of the jurisdiction from which the documents, materials or other information was received and originated.

(4) The disclosure of documents, materials or other information to the [*Department of Consumer and Business Services*] **authority** under this section, or the sharing of documents, materials or other information as authorized in subsection (3) of this section, does not waive any applicable privileges or claims of confidentiality in the documents, materials or other information.

(5) This section does not prohibit the [*department*] **authority** from releasing to a database or other clearinghouse service maintained by federal authorities a final, adjudicated order, including a certification, recertification, suspension or decertification of a qualified health plan under ORS 741.002, if the order is otherwise subject to public disclosure.

SECTION 34. ORS 741.520 is amended to read:

741.520. (1) The Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** may enter into agreements governing the sharing and use of information consistent with this section and ORS 741.510 with other state or federal health insurance exchanges or regulatory authorities, the [*Oregon Health Authority*] **Department of Consumer and Business Services**, the Department of Revenue, law enforcement agencies or federal authorities.

(2) An agreement under this section must specify the duration of the agreement, the purpose of the agreement, the methods that may be employed for terminating the agreement and any other necessary and proper matters.

(3) An agreement under this section does not relieve the director of any obligation or responsibility imposed by law.

(4) The director may expend funds and may supply services for the purpose of carrying out an agreement under this section.

SECTION 35. ORS 741.540 is amended to read:

741.540. (1) A complaint made to the **Oregon Health Authority or the** Department of Consumer and Business Services with respect to any prospective or certified qualified health plan, and the record thereof, shall be confidential and may not be disclosed except as provided in ORS 741.510 and 741.520. No such complaint, or the record thereof, shall be used by the **authority or the** department in any action, suit or proceeding except in the investigation or prosecution of apparent violations of ORS 741.310 or other law.

(2) Data gathered pursuant to an investigation of a complaint by the **authority or the** department shall be confidential, may not be disclosed except as provided in ORS 741.510 and 741.520 and may not be used in any action, suit or proceeding except in the investigation or prosecution of apparent violations of ORS 741.310 or other law.

(3) Notwithstanding subsections (1) and (2) of this section, the **authority and the** department shall establish a method for making available to the public an annual statistical report containing the number, percentage, type and disposition of complaints received by the **authority and the** department against each health plan that is certified or that has been certified as a qualified health plan by the [*department*] **authority**.

SECTION 36. ORS 741.802 is amended to read:

741.802. The [*Department of Consumer and Business Services*] **Oregon Health Authority** shall produce written materials containing information for consumers about the requirements for paying the premiums for qualified health plans. The [*department*] **authority** shall distribute the materials to health care providers upon request.

SECTION 37. ORS 741.900 is amended to read:

741.900. (1) The Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority**, in accordance with ORS 183.745, may impose a civil penalty for a violation of ORS 741.390 of no more than $10,000.

(2) All penalties recovered under this section shall be deposited in the Health Insurance Exchange Fund.

SECTION 38. ORS 743.018 is amended to read:

743.018. (1) Except for group life and health insurance, and except as provided in ORS 743.015, every insurer shall file with the Director of the Department of Consumer and Business Services all schedules and tables of premium rates for life and health insurance to be used on risks in this state, and shall file any amendments to or corrections of such schedules and tables. Premium rates are subject to approval, disapproval or withdrawal of approval by the director as provided in ORS 742.003, 742.005, 742.007 and, for health benefit plans as defined in ORS 743B.005, ORS 743.019.

(2) Except as provided in ORS 743B.013 and subsection (3) of this section, a rate filing by a carrier for any of the following health benefit plans subject to ORS 743.004, 743.022, 743.535 and 743B.003 to 743B.127 shall be available for public inspection immediately upon submission of the filing to the director:

1 (a) Health benefit plans for small employers.
2 (b) Individual health benefit plans.
3 (3) The director may by rule:
4 (a) Specify all information a carrier must submit as part of a rate filing under this section; and
5 (b) Identify the information submitted that will be exempt from disclosure under this section
6 because the information constitutes a trade secret and would, if disclosed, harm competition.
7 (4) The director, after conducting an actuarial review of the rate filing, may approve a proposed
8 premium rate for a health benefit plan for small employers or for an individual health benefit plan
9 if, in the director's discretion, the proposed rates are:
10 (a) Actuarially sound;
11 (b) Reasonable and not excessive, inadequate or unfairly discriminatory; and
12 (c) Based upon reasonable administrative expenses.
13 (5) In order to determine whether the proposed premium rates for a health benefit plan for small
14 employers or for an individual health benefit plan are reasonable and not excessive, inadequate or
15 unfairly discriminatory, the director may consider:
16 (a) The insurer's financial position, including but not limited to profitability, surplus, reserves
17 and investment savings.
18 (b) Historical and projected administrative costs and medical and hospital expenses, including
19 expenses for drugs reported under ORS 743.025.
20 (c) Historical and projected loss ratio between the amounts spent on medical services and
21 earned premiums.
22 (d) Any anticipated change in the number of enrollees if the proposed premium rate is approved.
23 (e) Changes to covered benefits or health benefit plan design.
24 (f) Changes in the insurer's health care cost containment and quality improvement efforts since
25 the insurer's last rate filing for the same category of health benefit plan.
26 (g) Whether the proposed change in the premium rate is necessary to maintain the insurer's
27 solvency or to maintain rate stability and prevent excessive rate increases in the future.
28 (h) Any public comments received under ORS 743.019 pertaining to the standards set forth in
29 subsection (4) of this section and this subsection.
30 **(6) The director shall require insurers to charge the same premium for a plan sold**
31 **through the health insurance exchange as the insurer charges for the identical plan sold**
32 **outside of the exchange.**
33 [*(6)*] **(7)** The requirements of this section do not supersede other provisions of law that require
34 insurers, health care service contractors or multiple employer welfare arrangements providing
35 health insurance to file schedules or tables of premium rates or proposed premium rates with the
36 director or to seek the director's approval of rates or changes to rates.
37 **SECTION 39.** ORS 743B.130 is amended to read:
38 743B.130. (1) In each individual or small group market, in which a carrier offers a health benefit
39 plan through or outside of the health insurance exchange described in ORS 741.310, the carrier must
40 offer to residents of this state bronze and silver plans certified by the [*Department of Consumer and*
41 *Business Services*] **Oregon Health Authority** as qualified health plans and meeting the require-
42 ments of [*subsection (2) of this section.*]
43 [*(2) The department shall prescribe by rule, in accordance with federal requirements, the form, level*
44 *of coverage and benefit design for the bronze and silver plans that must be offered under subsection*
45 *(1) of this section*] **ORS 741.310 (4)(a)(B)**.

[*(3)*] **(2)** As used in this section, "health benefit plan" has the meaning given that term in ORS 743B.005.

OPERATIVE DATE

SECTION 40. (1) Sections 1 to 8 of this 2021 Act and the amendments to ORS 243.142, 411.400, 411.402, 411.406, 413.011, 413.032, 414.025, 735.601, 735.608, 735.617, 741.002, 741.003, 741.004, 741.008, 741.102, 741.105, 741.107, 741.220, 741.222, 741.300, 741.310, 741.390, 741.400, 741.500, 741.510, 741.520, 741.540, 741.802, 741.900, 743.018 and 743B.130 by sections 9 to 39 of this 2021 Act become operative on June 30, 2021.

(2) The Director of the Department of Consumer and Business Services and the Director of the Oregon Health Authority shall take all steps necessary, prior to the operative date specified in subsection (1) of this section, to implement, on and after the operative date specified in subsection (1) of this section, sections 1 to 8 of this 2021 Act and the amendments to ORS 243.142, 411.400, 411.402, 411.406, 413.011, 413.032, 414.025, 735.601, 735.608, 735.617, 741.002, 741.003, 741.004, 741.008, 741.102, 741.105, 741.107, 741.220, 741.222, 741.300, 741.310, 741.390, 741.400, 741.500, 741.510, 741.520, 741.540, 741.802, 741.900, 743.018 and 743B.130 by sections 9 to 39 of this 2021 Act.

REPEAL

SECTION 41. (1) ORS 735.611 is repealed on June 30, 2021.

(2) Section 8 of this 2021 Act is repealed on June 30, 2023.

UNIT CAPTIONS

SECTION 42. The unit captions used in this 2021 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 2021 Act.

EMERGENCY CLAUSE

SECTION 43. This 2021 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2021 Act takes effect on its passage.