A-Engrossed
Senate Bill 1

Ordered by the Senate February 12
Including Senate Amendments dated February 12

Sponsored by Senator MONNES ANDERSON, Representative GREENLICK (at the request of Joint Interim Committee on Health Insurance Transition)

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.

Abolishes Oregon Health Insurance Exchange Corporation and board of directors of corporation and transfers **powers, rights, obligations, liabilities,** functions and duties to Department of Consumer and Business Services. Creates Health Insurance Exchange Advisory Committee and specifies duties.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to the health insurance exchange; creating new provisions; amending ORS 243.142, 243.886, 291.229, 291.231, 411.400, 413.011, 413.017, 413.085, 414.025, 414.736, 414.740, 414.826, 659A.200, 741.001, 741.002, 741.105, 741.201, 741.220, 741.222, 741.255, 741.300, 741.310, 741.381, 741.390, 741.400, 741.500, 741.510, 741.520, 741.540, 741.900, 743.730, 743.733, 743.822 and 743.826 and section 11, chapter 8, Oregon Laws 2012, and section 1, chapter 712, Oregon Laws 2013; repealing ORS 741.025, 741.027, 741.029, 741.031, 741.101 and 741.250 and section 27, chapter 415, Oregon Laws 2011, and section 2, chapter 74, Oregon Laws 2014; and declaring an emergency.

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

ABOLISHMENT OF OREGON HEALTH INSURANCE EXCHANGE CORPORATION

SECTION 1. (1) The Oregon Health Insurance Exchange Corporation board of directors is abolished and the tenure of office of the members of the board and the executive director ceases.

(2) All the powers, rights, obligations and liabilities of the board and the executive director are imposed upon, transferred to and vested in the Director of the Department of Consumer and Business Services.

SECTION 2. (1) The Oregon Health Insurance Exchange Corporation is abolished.

(2) All the duties and functions of the corporation are imposed upon, transferred to and vested in the Department of Consumer and Business Services.

(3) Employees of the corporation are not public employees for purposes of ORS 236.605 to 236.640.

RECORDS AND PROPERTY

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.

SECTION 3. **The Director of the Department of Consumer and Business Services shall take possession of all records and property of the Oregon Health Insurance Exchange Corporation that relate to the duties and functions transferred by section 2 of this 2015 Act. The director shall take possession of the records and property in the name of the State of Oregon.**

UNEXPENDED REVENUES

SECTION 4. **The moneys in the accounts established under ORS 741.101 and the unexpended balances of amounts authorized to be expended by the Oregon Health Insurance Exchange Corporation for the biennium beginning July 1, 2013, from revenues dedicated, continuously appropriated, appropriated or otherwise made available for the purpose of administering and enforcing the duties and functions transferred by section 2 of this 2015 Act are transferred to the Health Insurance Exchange Fund established in section 14 of this 2015 Act and are available for expenditure by the Department of Consumer and Business Services for the biennium beginning July 1, 2013, for the purpose of administering and enforcing the duties and functions transferred by section 2 of this 2015 Act.**

ACTION, PROCEEDING, PROSECUTION

SECTION 5. **The transfer of powers, rights, obligations and liabilities to the Director of the Department of Consumer and Business Services by section 1 of this 2015 Act does not affect any action, proceeding or prosecution involving or with respect to such powers, rights, obligations and liabilities begun before and pending at the time of the transfer, except that the State of Oregon, by and through the Department of Consumer and Business Services, is substituted for the Oregon Health Insurance Exchange Corporation in the action, proceeding or prosecution.**

LIABILITY, DUTY, OBLIGATION

SECTION 6. **(1) Nothing in sections 1 to 14 and 36 of this 2015 Act, the amendments to ORS 243.142, 243.886, 291.229, 291.231, 411.400, 413.011, 413.017, 413.085, 414.025, 414.736, 414.740, 414.826, 659A.200, 741.001, 741.002, 741.105, 741.201, 741.220, 741.222, 741.255, 741.300, 741.310, 741.381, 741.390, 741.400, 741.500, 741.510, 741.520, 741.540, 741.900, 743.730, 743.733, 743.822 and 743.826 and section 14 of this 2015 Act and section 11, chapter 8, Oregon Laws 2012, and section 1, chapter 712, Oregon Laws 2013, by sections 15 to 26, 28 to 34 and 37 to 56 of this 2015 Act and the repeal of ORS 741.025, 741.027, 741.029, 741.031, 741.101 and 741.250 and section 27, chapter 415, Oregon Laws 2011, and section 2, chapter 74, Oregon Laws 2014, by sections 58 and 59 of this 2015 Act relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions, powers, rights, obligations and liabilities transferred by sections 1 and 2 of this 2015 Act. The Director of the Department of Consumer and Business Services may undertake the collection or enforcement of any such liability, duty or obligation.**

(2) The rights, obligations and liabilities of the Oregon Health Insurance Exchange Corporation legally incurred before the operative date of section 1 of this 2015 Act are trans-

ferred to the Department of Consumer and Business Services. The department is the successor to those rights, obligations and liabilities, notwithstanding any prohibition on assignment contained in contracts assumed by the department under sections 1 and 2 of this 2015 Act.

(3) Notwithstanding sections 1 to 5 of this 2015 Act, the rights, obligations and liabilities transferred to the department:

(a) Are subject to the limitations, defenses and immunities of the department that arise under ORS 30.260 to 30.300, the Eleventh Amendment to the United States Constitution and other state and federal laws;

(b) Shall be amended or reformed as necessary to comply with the Public Contracting Code; and

(c) Shall be amended or reformed as necessary for the department to be named the grantee for any federal grants.

RULES

SECTION 7. Notwithstanding the transfer of duties and functions by section 2 of this 2015 Act, the rules of the Oregon Health Insurance Exchange Corporation in effect on the operative date of section 2 of this 2015 Act continue in effect until superseded or repealed by rules of the Department of Consumer and Business Services. References in rules of the corporation to the corporation or an officer or employee of the corporation are considered to be references to the department or an officer or employee of the department.

NAME SUBSTITUTION

SECTION 8. Whenever, in any statutory law or resolution of the Legislative Assembly or in any rule, document, record or proceeding authorized by the Legislative Assembly, reference is made to the Oregon Health Insurance Exchange Corporation board of directors or the executive director, the reference is considered to be a reference to the Director of the Department of Consumer and Business Services.

SECTION 9. Whenever, in any statutory law or resolution of the Legislative Assembly or in any rule, document, record or proceeding authorized by the Legislative Assembly, reference is made to the Oregon Health Insurance Exchange Corporation or an employee of the corporation, the reference is considered to be a reference to the Department of Consumer and Business Services or an employee of the department.

SECTION 10. For the purpose of harmonizing and clarifying statutory law, the Legislative Counsel may substitute for words designating the "Oregon Health Insurance Exchange Corporation" or its officers, wherever they occur in statutory law, words designating the "Department of Consumer and Business Services" or its officers.

DIRECTORS MAY TAKE ACTIONS PRIOR TO OPERATIVE DATE

SECTION 11. The Director of the Department of Consumer and Business Services, the Oregon Health Insurance Exchange Corporation and the Director of the Oregon Health Au-

thority may take any action before the operative date of section 2 of this 2015 Act that is necessary to enable the Department of Consumer and Business Services to exercise, on and after the operative date of section 2 of this 2015 Act, the duties and functions of the corporation pursuant to section 2 of this 2015 Act.

CREATION OF ADVISORY COMMITTEE AND FUND

SECTION 12. Sections 13 and 14 of this 2015 Act are added to and made a part of ORS 741.001 to 741.540.

SECTION 13. (1) The Health Insurance Exchange Advisory Committee is created to advise the Director of the Department of Consumer and Business Services 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 health benefit plans through the health insurance exchange.

(d) The affordability of 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 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 and the Director of the Oregon Health Authority 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 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 may solicit recommendations from the committee and the committee may initiate recommendations on its own.

(5) The committee shall 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 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 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 section 14 of this 2015 Act.

(7) The employees of the Department of Consumer and Business Services 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 14. 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 under ORS 741.001 to 741.540 and moneys transferred under section 4 of this 2015 Act. Moneys in the fund are continuously appropriated to the department for carrying out the purposes of ORS 741.001 to 741.540.

SECTION 15. Section 14 of this 2015 Act is amended to read:

Sec. 14. 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 under ORS 741.001 to 741.540 [*and moneys transferred under section 4 of this 2015 Act*]. Moneys in the fund are continuously appropriated to the department for carrying out the purposes of ORS 741.001 to 741.540.

TRANSFER OF EXCHANGE DUTIES AND FUNCTIONS TO DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

SECTION 16. ORS 741.001 is amended to read:

741.001. [*(1) The Oregon Health Insurance Exchange Corporation is established as a public corporation performing governmental functions and exercising governmental powers. The corporation shall exercise and carry out statewide all the powers, rights and privileges that are expressly conferred upon the corporation, are implied by law or are incident to such powers. Nothing in this section or ORS 741.002 or 741.310 is intended to affect the regulatory responsibilities of the Department of Consumer*

and Business Services under the Insurance Code.]

[*(2) The mission of the corporation is to:*] **It is the intent of the Legislative Assembly that the health insurance exchange be administered in such a manner as to:**

[*(a)*] **(1)** Incorporate the goals of improving the lifelong health of all Oregonians, increasing the quality, reliability and availability of health insurance for all Oregonians and lowering or containing the cost of health insurance so that health insurance is affordable to everyone.

[*(b)*] **(2)** [*Administer a health insurance exchange in the*] **Promote the** public interest **and** for the benefit of the people and businesses that obtain health insurance coverage for themselves, their families and their employees through the exchange.

[*(c)*] **(3)** Empower Oregonians by giving them the information and tools they need to make health insurance choices that meet their needs and values.

[*(d)*] **(4)** Improve health care quality and public health, mitigate health disparities linked to race, ethnicity, primary language and similar factors, control costs and ensure access to affordable, equitable and high-quality health care throughout this state.

[*(e)*] **(5)** Be accountable to the public.

[*(f)*] **(6)** Encourage the development of new health insurance products that offer innovative:

[*(A)*] **(a)** Benefit packages for the coverage of health care services;

[*(B)*] **(b)** Health care delivery systems; and

[*(C)*] **(c)** Payment mechanisms.

SECTION 17. ORS 741.002 is amended to read:

741.002. (1) The duties of the [*Oregon Health Insurance Exchange Corporation are to*] **Department of Consumer and Business Services include**:

(a) [*Administer*] **Administering** a health insurance exchange in accordance with federal law to make qualified health plans available to individuals and groups throughout this state.

(b) [*Provide*] **Providing** information in writing, through an Internet-based clearinghouse and through a toll-free telephone line**,** that will assist individuals and small businesses in making informed health insurance decisions[*, including*] **and that may include**:

(A) The [*grade of*] **rating assigned to** each health plan [*as determined by the corporation*] and the [*grading*] **rating** criteria that were used;

(B) Quality and enrollee satisfaction [*ratings*] **survey results**; and

(C) The comparative costs, benefits, provider networks of health plans and other useful information.

(c) [*Establish and make available*] **Establishing and maintaining** an electronic calculator that allows individuals and employers to determine the cost of coverage after deducting any applicable tax credits or cost-sharing reduction.

(d) Operating a call center for answers to questions from individuals seeking enrollment in a qualified health plan or in the state medical assistance program.

(e) Providing information about the eligibility requirements and the application processes for the state medical assistance program.

[*(d)*] **(2)** [*Using procedures approved by the corporation's board of directors and adopted by rule by the corporation under ORS 741.310,*] **The department shall:**

(a) Screen, certify and recertify health plans as qualified health plans according to [*federal and state standards*] **the requirements, standards and criteria adopted by the department under ORS 741.310** and ensure that qualified health plans provide choices of coverage.

[*(e)*] **(b)** Decertify or suspend, in accordance with ORS chapter 183, the certification of **a** health

[*plans*] **plan** that [*fail*] **fails** to meet federal and state standards in order to exclude [*them*] **the health plan** from participation in the exchange.

[*(f)*] **(c)** Promote fair competition of carriers participating in the exchange by certifying multiple health plans as qualified under ORS 741.310.

[*(g)*] **(d)** [*Grade*] **Assign ratings to** health plans in accordance with criteria established by the United States Secretary of Health and Human Services and by the [*corporation*] **department**.

[*(h)*] **(e)** Establish open and special enrollment periods for all enrollees, and monthly enrollment periods for Native Americans in accordance with federal law.

[*(i)*] **(f)** Assist individuals and groups to enroll in qualified health plans, including defined contribution plans as defined in section 414 of the Internal Revenue Code and, if appropriate, collect and remit premiums for such individuals or groups.

[*(j)*] **(g)** Facilitate community-based assistance with enrollment in qualified health plans by awarding grants to entities that are certified as navigators as described in 42 U.S.C. 18031(i).

[*(k) Provide information to individuals and employers regarding the eligibility requirements for state medical assistance programs and assist eligible individuals and families in applying for and enrolling in the programs.*]

[*(L)*] **(h)** Provide employers with the names of employees who end coverage under a qualified health plan during a plan year.

[*(m)*] **(i)** Certify the eligibility of an individual for an exemption from the individual responsibility requirement of section 5000A of the Internal Revenue Code.

[*(n)*] **(j)** Provide information to the federal government necessary for individuals who are enrolled in qualified health plans through the exchange to receive tax credits and reduced cost-sharing.

[*(o)*] **(k)** Provide to the federal government **any information necessary to comply with federal requirements including**:

(A) Information regarding individuals determined to be exempt from the individual responsibility requirement of section 5000A of the Internal Revenue Code;

(B) Information regarding employees who have reported a change in employer; **and**

(C) Information regarding individuals who have ended coverage during a plan year[*; and*]

[*(D) Any other information necessary to comply with federal requirements*].

[*(p)*] **(L)** Take any other actions necessary and appropriate to comply with the federal requirements for a health insurance exchange.

[*(q)*] **(m)** Work in coordination with the Oregon Health Authority[,] **and** the Oregon Health Policy Board [*and the Department of Consumer and Business Services*] in carrying out its duties.

[*(2) The corporation may sue and be sued.*]

[*(3) The corporation may:*]

[*(a) Acquire, lease, rent, own and manage real property.*]

[*(b) Construct, equip and furnish buildings or other structures as are necessary to accommodate the needs of the corporation.*]

[*(c) Purchase, rent, lease or otherwise acquire for the corporation's use all supplies, materials, equipment and services necessary to carry out the corporation's duties.*]

[*(d) Sell or otherwise dispose of any property acquired under this subsection.*]

[*(e) Borrow money and give guarantees to finance its facilities and operations.*]

[*(4) Any real property acquired and owned by the corporation under this section shall be subject to ad valorem taxation.*]

[*(5) The corporation may not borrow money or give guarantees under subsection (3)(e) of this section unless the obligations of the corporation are payable solely out of the corporation's own resources and do not constitute a pledge of the full faith and credit of the State of Oregon or any of the revenues of this state. The State Treasurer and the State of Oregon may not pay bond-related costs for an obligation incurred by the corporation. A holder of an obligation incurred by the corporation does not have the right to compel the exercise of the taxing power of the state to pay bond-related costs.*]

[*(6)*] **(3)** The [*corporation*] **department** may adopt rules necessary to carry out its [*mission,*] duties and functions **under ORS 741.001 to 741.540**.

(4) The department may contract or enter into an intergovernmental agreement with the federal government to perform any of the duties and functions described in ORS 741.001 to 741.540.

(5) The department may assign contracts to the Oregon Health Authority if necessary for the authority to administer the state medical assistance program.

SECTION 18. ORS 741.105 is amended to read:

741.105. (1) The [*Oregon Health Insurance Exchange Corporation board of directors*] **Department of Consumer and Business Services** shall establish, [*and the corporation shall impose and collect*] **by rule**, an administrative **charge. The department 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 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 [*corporation*] **department** in carrying out ORS 741.001 to 741.540. The charge shall be paid in a manner and at intervals prescribed by the [*board and shall be deposited in an account established in ORS 741.101*] **department**.

(2) Each insurer's charge shall be based on the number of individuals, excluding individuals enrolled in state programs, who are enrolled in health plans offered by the insurer through the exchange. The assessment on each state program shall be based on the number of individuals enrolled in state programs offered through the exchange. The charge 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) If charges collected under subsection (1) of this section exceed the amounts needed for the administrative and operational expenses of the [*corporation*] **department in administering the health insurance exchange**, the excess moneys collected may be held and [*invested and, with the earnings and interest,*] used by the [*corporation*] **department** to offset future net losses [*or reduce the administrative costs of the corporation*].

[*(b) Investments made by the corporation under this subsection are:*]

[*(A) Limited to investments described in ORS 294.035;*]

[*(B) Subject to the investment maturity date limitations described in ORS 294.135; and*]

[*(C) Subject to the conduct prohibitions listed in ORS 294.145.*]

[*(c)*] **(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**

anticipated by the [*corporation*] **department** for a six-month period. Any moneys received that exceed the maximum shall be applied by the [*corporation*] **department** to reduce the charges imposed by this section.

(4) Charges shall be based on annual statements and other reports [*deemed necessary by the corporation and filed by an insurer or state program with the exchange*] **submitted by insurers and state programs as prescribed by the department**.

(5) In addition to charges imposed under subsection (1) of this section, to the extent permitted by federal law the [*corporation*] **department** 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 [*corporation*] **department or by the United States Department of Health and Human Services** to facilitate the participation of individuals and employers in the exchange.

(6)**(a)** The [*board*] **Department of Consumer and Business Services** shall establish **and amend** the charges and fees under this section in accordance with ORS 183.310 to 183.410 [*and in such a manner that will reasonably and substantially accomplish the objective of subsections (1) and (5) of this section*].

(b) If the department 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 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 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) All charges and fees collected under this section shall be deposited in the Health Insurance Exchange Fund.

SECTION 19. ORS 741.201 is amended to read:

741.201. (1) The [*Oregon Health Insurance Exchange Corporation*] **health insurance exchange** is under the supervision of [*an executive director appointed by the corporation board of directors. The executive director serves at the pleasure of the board. The executive director shall be paid a salary as prescribed by the board*] **the Director of the Department of Consumer and Business Services**.

[*(2) Before assuming the duties of the office, the executive director shall:*]

[*(a) Give to the state a fidelity bond, with one or more corporate sureties authorized to do business in this state, in a penal sum prescribed by the Director of the Oregon Department of Administrative Services, but not less than $50,000. The premium for the bond shall be paid from an account established under ORS 741.101.*]

[*(b) Subscribe to an oath that the executive director faithfully and impartially will discharge the duties of the office and that the executive director will support the Constitution of the United States and the Constitution of the State of Oregon. The executive director shall file a copy of the signed oath with the Secretary of State.*]

[*(3)*] **(2)** The [*executive*] director has such [*other*] powers as are necessary to carry out [*the duties*

of the corporation, subject to policy direction by the board] **ORS 741.001 to 741.540**.

[*(4)*] **(3)** The [*executive*] director may employ, supervise and terminate the employment of such staff as the [*executive*] director deems necessary. The [*executive*] director shall prescribe their duties and fix their compensation [*, in accordance with the personnel policies adopted by the board. Employees of the corporation may not be individuals who are*]**. An employee of the department, other than the director, who has management responsibilities or decision-making authority with respect to the administration of the health insurance exchange may not also have 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;

(B) An insurance producer; or

(C) A health care provider, health care facility or health clinic;

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

(A) Insurers or third party administrators; or

(B) Health care providers, health care facilities or health clinics; 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.

[*(5)(a) The board shall adopt personnel policies, subject to ORS 236.605 to 236.640, for any transferred public employees. The board may elect to provide for participation in a health benefit plan available to state employees pursuant to ORS 243.105 to 243.285 and may elect to participate in the state deferred compensation plan established under ORS 243.401 to 243.507. If the board so elects, employees of the corporation shall be considered eligible employees for purposes of ORS 243.105 to 243.285 and eligible state employees for purposes of ORS 243.401 to 243.507.*]

[*(b) In order to facilitate the development of innovative health benefit plans, the board or the executive director may contract with one or more carriers to offer to employees of the Oregon Health Insurance Exchange Corporation proof of concept health benefit plans approved by the director of the Department of Consumer and Business Services. A plan offered under this paragraph is not subject to ORS 743.730 to 743.773.*]

[*(6) With respect to the Public Employees Retirement System, employees of the corporation shall be considered employees for purposes of ORS chapter 238 and eligible employees for purposes of ORS chapter 238A.*]

[*(7) Employees of the corporation may participate in collective bargaining in accordance with ORS 243.650 to 243.782.*]

SECTION 20. ORS 741.220 is amended to read:

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

(2) [*Beginning after the first 12 months of the operation of the exchange and every 12 months thereafter,*] The Secretary of State shall conduct [*a*] **an annual** financial audit of the [*corporation and the accounts established under ORS 741.101 pursuant to ORS 297.210, which*] **department'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 [*accounts*] **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) [*Beginning after the first 24 months of the operation of the exchange and*] Every two years [*thereafter*], the Secretary of State shall conduct a performance audit of the [*corporation and the*] exchange.

(4) The [*corporation board of directors, the executive director of the corporation and employees of the corporation*] **Director of the Department of Consumer and Business Services and employees of the department** 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 [*corporation*] **department**.

(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[*, the Department of Consumer and Business Services*] 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 [*corporation*] **department** by federal authorities, the Secretary of State and the [*corporation*] **department** 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 [*corporation*] **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 21. ORS 741.222 is amended to read:

741.222. (1) The [*executive director of the Oregon Health Insurance Exchange Corporation*] **Director of the Department of Consumer and Business Services** shall report to the Legislative Assembly each [*calendar quarter*] **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);

[*(b) The implementation of the business plan adopted by the corporation board of directors;*]

[*(c)*] **(b)** The development of the information technology system for the exchange;

[*(d)*] **(c)** Efforts made, in collaboration with the Oregon Health Authority, to coordinate eligibility determination and enrollment processes for qualified health plans and the state medical assistance program; [*and*]

(d) The progress of integrating the duties and functions transferred to the Department of Consumer and Business Services under section 2 of this 2015 Act;

(e) The progress in planning for, developing and implementing a Small Business Health Options Program, including the key decision points, timelines and a description of how the department is engaging stakeholders in the design and decision-making process for the SHOP;

(f) The outstanding liabilities, if any, carried over from the Oregon Health Insurance Exchange Corporation;

(g) Any agreements entered into or modification of existing agreements with federal agencies necessitated by the department's assumption of the responsibility for administering the exchange; and

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

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

(a) A report covering the activities and operations of the [*corporation*] **department 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 [*accounts established under ORS 741.101*] **Health Insurance Exchange Fund**;

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

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

(3) The director shall report the information described in subsection (1) of this section at each scheduled meeting of the Joint Interim Committee on Ways and Means and at each scheduled meeting of the interim committees related to health, occurring between September 1, 2015, and June 30, 2017.

SECTION 22. ORS 741.222, as amended by section 3, chapter 368, Oregon Laws 2013, is amended to read:

741.222. (1) The [*executive director of the Oregon Health Insurance Exchange Corporation*] **Director of the Department of Consumer and Business Services** shall report to the Legislative Assembly each [*calendar quarter*] **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);

(b) The implementation of the [*business plan adopted by the corporation board of directors*] **Small Business Health Options Program**;

(c) The development of the information technology system for the exchange; and

(d) Any other information requested by the leadership of the Legislative Assembly.

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

(a) A report covering the activities and operations of the [*corporation*] **Department of Consumer and Business Services 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 [*accounts established under ORS 741.101*] **Health Insurance Exchange Fund**;

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

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

SECTION 23. ORS 741.255 is amended to read:

741.255. The [*Oregon Health Insurance Exchange Corporation*] **Department of Consumer and Business Services** shall conduct a state or nationwide criminal records check under ORS 181.534 on, and for that purpose may require the fingerprints of**,** a person who:

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

(2) Is, or will be, providing services to the [*corporation*] **department** 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 [*corporation*] **department**;

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

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

(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 24. 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.

[*(1)*] **(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 743.730.

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

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

[*(4)*] **(6)** "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)*] **(7)** "Health plan" means health insurance**, a health benefit plan** or health care coverage offered by an insurer.

[*(6)*] **(8)** "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.

[*(7)*] **(9)** "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)*] **(10)** "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 [*through*] **to employees by** the Public Employees' Benefit Board or the Oregon Educators Benefit Board.

(11) "Qualified health plan" means a health benefit plan available for purchase through the health insurance exchange.

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

SECTION 25. ORS 741.310, as amended by section 12, chapter 415, Oregon Laws 2011, section 11, chapter 38, Oregon Laws 2012, section 97, chapter 107, Oregon Laws 2012, and section 2, chapter 421, Oregon Laws 2013, is amended to read:

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

(b) The following [*individuals and*] groups may purchase qualified health plans through the [*health insurance exchange*] **Small Business Health Options Program**:

[*(a) Individuals and families;*]

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

[*(c)*] **(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 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*] **SHOP** 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*] **ORS 741.002**. [*Prepaid managed care health services*] **Coordinated care** 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*] **Department of Consumer and Business Services** 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*] **department** 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.

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

(6) The [*corporation*] **department, in collaboration with the Oregon Health Authority and the Department of Human Services,** shall [*establish one streamlined and seamless*] **coordinate the** application and enrollment [*process for both*] **processes for** the exchange and the state medical assistance program.

(7) The [*corporation, in collaboration with the appropriate state authorities,*] **Department of Consumer and Business Services** may establish risk mediation programs within the exchange.

(8) The [*corporation*] **department** 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*] **department** 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*] **department** is authorized to enter into contracts for the performance of **the department's** duties, functions or operations [*of*] **with respect to** 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**, in-person assisters and application counselors** certified by the [*corporation*] **department** under ORS 741.002.

(11)(a) The [*corporation*] **department** shall consult with stakeholders, including but not limited to representatives of school administrators, school board members, school employees and the Oregon Educators Benefit Board, regarding the plans that may be offered through the exchange to districts and eligible employees of districts under subsection [*(1)(c)*] **(1)(b)(B)** of this section and the insurers that may offer the plans.

(b) The board and the [*corporation*] **department** shall each adopt rules to ensure that:

(A) Any plan offered under subsection [*(1)(c)*] **(1)(b)(B)** of this section is underwritten by an insurer using a single risk pool composed of all eligible employees who are enrolled or who will be enrolled in the plan both through the exchange and by the board; and

(B) In every plan offered under subsection [*(1)(c)*] **(1)(b)(B)** of this section, the coverage is comparable to plans offered by the board.

(12) The [*corporation*] **department** 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*] **the Health Insurance Exchange Fund**.

SECTION 26. ORS 741.381 is amended to read:

741.381. The activities of insurers working under the direction of the Oregon Health Authority[*, the Oregon Health Insurance Exchange Corporation*] and the Department of Consumer and Business Services pursuant to ORS 413.011 (1)(j) or participating in the health insurance exchange administered under ORS 741.002 do not constitute a conspiracy or restraint of trade or an illegal monopoly, nor are they carried out for the purposes of lessening competition or fixing prices arbitrarily.

SECTION 27. ORS 741.390 and 741.400 are added to and made a part of ORS 741.001 to 741.540.

SECTION 28. ORS 741.390 is amended to read:

741.390. A person may not file or cause to be filed with the [*executive director of the Oregon Health Insurance Exchange Corporation*] **Department of Consumer and Business Services** any article, certificate, report, statement, application or any other information **related to the health insurance exchange** required or permitted by the [*executive director*] **department** to be filed, that is known by the person to be false or misleading in any material respect.

SECTION 29. ORS 741.400 is amended to read:

741.400. (1) The [*Oregon Health Insurance Exchange Corporation*] **Department of Consumer and Business Services** may serve by regular mail or, if requested by the recipient, by electronic mail a notice described in ORS 183.415 of the [*corporation's*] **department's** determination of:

(a) A person's eligibility to purchase or to continue to purchase a qualified health plan through the health insurance exchange;

(b) A person's eligibility for a premium tax credit for purchasing a qualified health plan or the amount of the person's premium tax credit; or

(c) A person's eligibility for cost-sharing reductions for qualified health plans and the amount of the person's cost-sharing reduction.

(2) The legal presumption described in ORS 40.135 (1)(q) does not apply to a notice that is served by regular or electronic mail in accordance with subsection (1) of this section.

(3) Except as provided in subsection (4) of this section, a contested case notice served in accordance with subsection (1) of this section that complies with ORS 183.415 but for service by regular or electronic mail becomes a final order against a party and is not subject to ORS 183.470 (2), upon the earlier of the following:

(a) If the party fails to request a hearing, the day after the date prescribed in the notice as the deadline for requesting a hearing.

(b) The date the [*corporation*] **department** or the Office of Administrative Hearings mails an order dismissing a hearing request because:

(A) The party withdraws the request for hearing; or

(B) Neither the party nor the party's representative appears on the date and at the time set for hearing.

(4) The [*corporation*] **department** shall prescribe by rule a period of not less than 60 days after a notice becomes a final order under subsection (3) of this section within which a party may request a hearing under this subsection. If a party requests a hearing within the period prescribed under this subsection, the [*corporation*] **department** shall do one of the following:

(a) If the [*corporation*] **department** finds that the party did not receive the written notice and did not have actual knowledge of the notice, refer the request for hearing to the Office of Administrative Hearings for a contested case proceeding on the merits of the [*corporation's*] **department's** intended action described in the notice.

(b) Refer the request for hearing to the Office of Administrative Hearings for a contested case proceeding to determine whether the party received the written notice or had actual knowledge of the notice. The [*corporation*] **department** must show that the party had actual knowledge of the notice or that the [*corporation*] **department** mailed the notice to the party's correct address or sent an electronic notice to the party's correct electronic mail address.

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

SECTION 30. ORS 741.500 is amended to read:

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

(A) Health plan coverage through the health insurance exchange;

(B) Premium tax credits; and

(C) Cost-sharing reductions.

(b) The documentation specified by the [*corporation*] **department** 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 [*corporation*] **department** 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 [*corporation*] **department** shall implement systems that provide electronic access to, and use, disclosure and validation of data needed to administer the [*duties, functions and operation of the corporation*] **exchange**, to comply with federal data access and data exchange requirements and to streamline and simplify **exchange** processes [*of the corporation*].

(4) Information and data that the [*corporation*] **department** 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 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 [*other programs administered by the corporation and*] for program analysis.

SECTION 31. 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 [*Oregon Health Insurance Exchange Corporation*] **Department of Consumer and Business Services** 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 192.410 to 192.505 or subject to subpoena or discovery or admissible into evidence in any private civil action in which the [*corporation*] **department** is not a named party. The [*executive director of the corporation*] **department** 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) [*In order to assist in the performance of the executive director's duties,*] The [*executive*] Director **of the Department of Consumer and Business Services** may:

(a) Authorize the sharing of confidential documents, materials or other information that is subject to subsection (1) of this section within the [*corporation*] **department** and subject to any conditions on further disclosure, for the purpose of carrying out the duties and functions of the [*corporation*] **department 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 192.501 or 192.502 with other state or federal health insurance exchanges or regulatory authorities, the Oregon Health Authority, the Department of [*Consumer and Business Services*] **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, the Department of [*Consumer and Business Services*] **Revenue**, law enforcement agencies or federal authorities. The [*executive director*] **Department of Consumer and Business Services** 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 [*executive director*] **Department of Consumer and Business Services** 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 [*executive director*] **department** 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 32. ORS 741.520 is amended to read:

741.520. (1) The [*executive director of the Oregon Health Insurance Exchange Corporation*] **Director of the Department of Consumer and Business Services** 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, [*the 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 [*executive*] director of any obligation or responsibility imposed by law.

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

[*(5) Agreements under this section are exempt from ORS 190.410 to 190.440 and 190.480 to 190.490.*]

SECTION 33. ORS 741.540 is amended to read:

741.540. (1) A complaint made to the [*executive director of the Oregon Health Insurance Exchange*

Corporation] **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 department** in any action, suit or proceeding except [*to the extent considered necessary by the executive director*] 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 [*executive director*] **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 [*to the extent considered necessary by the executive director*] 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 [*executive director*] **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 [*corporation*] **department** against each health plan that is certified or that has been certified as a qualified health plan by the [*corporation*] **department**.

SECTION 34. ORS 741.900 is amended to read:

741.900. (1) The [*executive director of the Oregon Health Insurance Exchange Corporation*] **Director of the Department of Consumer and Business Services**, in accordance with ORS 183.745, may impose a civil penalty [*under*] **for a violation of** ORS 741.390 of no more than $10,000. [*The penalty may not be imposed on carriers for violations of ORS 741.390 unless imposed by the Department of Consumer and Business Services pursuant to the department's regulatory functions.*]

(2) All penalties recovered under this section shall be [*paid to the State Treasury and credited to the General Fund*] **deposited in the Health Insurance Exchange Fund**.

SECTION 35. Section 36 of this 2015 Act is added to and made a part of the Insurance Code.

SECTION 36. Health benefit plans offered through a Small Business Health Options Program, as defined in ORS 741.300, are subject to ORS 743.730 to 743.773 and to other provisions of the Insurance Code applicable to small employer group health insurance.

SECTION 36a. (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 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 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 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 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.

CONFORMING AMENDMENTS

SECTION 37. ORS 243.142 is amended to read:

243.142. The [*Oregon Health Insurance Exchange Corporation*] **Department of Consumer and Business Services** 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 38. ORS 243.886, as amended by section 13, chapter 38, Oregon Laws 2012, and section 2, chapter 780, Oregon Laws 2013, is amended to read:

243.886. (1) Except as provided in subsections (2), (3) and (4) of this section, a district may not provide or contract for a benefit plan and eligible employees of districts may not participate in a benefit plan unless the benefit plan:

(a) Is provided and administered by the Oregon Educators Benefit Board under ORS 243.860 to 243.886; or

(b) Is offered through the health insurance exchange under ORS 741.310 [*(1)(c)*] **(1)(b)(B)**.

(2)(a) Except for community college districts, a district that was self-insured before January 1, 2007, or a district that had an independent health insurance trust established and functioning before January 1, 2007, may provide or contract for benefit plans other than benefit plans provided and administered by the board if the premiums for the benefit plans provided or contracted for by the district are equal to or less than the premiums for comparable benefit plans provided and administered by the board.

(b) A community college district may provide or contract for benefit plans other than benefit plans provided and administered by the board.

(c) In accordance with procedures adopted by the board to extend benefit plan coverage under ORS 243.864 to 243.874 to eligible employees of a self-insured district, a district with an independent health insurance trust or a community college district, these districts may choose to offer benefit plans that are provided and administered by the board. Once employees of a district participate in benefit plans provided and administered by the board, the district may not thereafter provide or contract for benefit plans other than those provided and administered by the board.

(3)(a) A district, other than a district claiming the exception in subsection (2)(a) of this section, that has not offered benefit plans provided and administered by the board before June 23, 2009, may provide or contract for benefit plans other than benefit plans provided and administered by the board if the premiums for the benefit plans provided or contracted for by the district are equal to or less than the premiums for comparable benefit plans provided and administered by the board. Once employees of a district or an employee group within a district participates in benefit plans provided and administered by the board, the district may not thereafter provide or contract for benefit plans for those employees or employee groups other than those provided and administered by the board.

(b) If requested by the district or a labor organization representing eligible employees of the district, the board shall perform an actuarial analysis of the district.

(c) As used in this subsection, "district" does not include a community college district.

(4) Nothing in ORS 243.860 to 243.886 may be construed to expand or contract collective bar-

gaining rights or collective bargaining obligations.

SECTION 39. ORS 291.229 is amended to read:

291.229. (1) As part of the development of the legislatively adopted budget in each odd-numbered year regular session of the Legislative Assembly, the Oregon Department of Administrative Services shall make a report to the Joint Committee on Ways and Means on the actions taken by state agencies during the previous biennium to attain a ratio of at least 11 nonsupervisory employees to every supervisory employee, as defined in ORS 243.650.

(2) As used in this section:

(a) "State agency" means all state officers, boards, commissions, departments, institutions, branches, agencies, divisions and other entities, without regard to the designation given to those entities, that are within the executive branch of government as described in Article III, section 1, of the Oregon Constitution.

(b) "State agency" does not include:

(A) The legislative department as defined in ORS 174.114;

(B) The judicial department as defined in ORS 174.113;

(C) The Public Defense Services Commission;

(D) The Secretary of State and the State Treasurer in the performance of the duties of their constitutional offices;

(E) Semi-independent state agencies listed in ORS 182.454;

(F) The Oregon Tourism Commission;

(G) The Oregon Film and Video Office;

(H) The Oregon University System;

(I) The Oregon Health and Science University;

(J) The Travel Information Council;

(K) Oregon Corrections Enterprises;

(L) The Oregon State Lottery Commission;

(M) The State Accident Insurance Fund Corporation;

[*(N) The Oregon Health Insurance Exchange Corporation;*]

[*(O)*] **(N)** The Oregon Utility Notification Center;

[*(P)*] **(O)** Oregon Community Power;

[*(Q)*] **(P)** The Citizens' Utility Board;

[*(R)*] **(Q)** A special government body as defined in ORS 174.117;

[*(S)*] **(R)** Any other public corporation created under a statute of this state and specifically designated as a public corporation; and

[*(T)*] **(S)** Any other semi-independent state agency denominated by statute as a semi-independent state agency.

SECTION 40. ORS 291.231 is amended to read:

291.231. (1) Notwithstanding ORS 291.229, a state agency that employs more than 100 employees and has not, by April 11, 2012, attained a ratio of at least 11 to 1 of employees of the state agency who are not supervisory employees to supervisory employees:

(a) May not fill the position of a supervisory employee until the agency has increased the agency's ratio of employees to supervisory employees so that the ratio is at least one additional employee to supervisory employees; and

(b) Shall, not later than October 31, 2012, lay off or reclassify the number of supervisory employees necessary to attain the increase in the ratio specified in paragraph (a) of this subsection if

the increase in that ratio is not attained under paragraph (a) of this subsection or through attrition.

(2) Notwithstanding ORS 291.229, a state agency that employs more than 100 employees and has complied with the requirements of subsection (1) of this section, but has not attained a ratio of at least 11 to 1 of employees of the state agency who are not supervisory employees to supervisory employees:

(a) May not fill the position of a supervisory employee until the agency has increased the agency's ratio of employees to supervisory employees by at least one additional employee; and

(b) Not later than October 31 of each subsequent year, shall lay off or reclassify the number of supervisory employees necessary to increase the agency's ratio of employees to supervisory employees so that the ratio is at least one additional employee to supervisory employees.

(3) Layoffs or reclassifications required under this section must be made in accordance with the terms of any applicable collective bargaining agreement. A supervisory employee who is reclassified into a classified position pursuant to this section shall be compensated in the salary range for the classified position unless otherwise provided by an applicable collective bargaining agreement.

(4) Upon application from a state agency, the Director of the Oregon Department of Administrative Services may grant a state agency an exception from the requirements of subsections (1) to (3) of this section. The director may grant an exception under this section that:

(a) Applies to a particular position if the director determines the exception is necessary to allow the state agency to maintain public or state agency employee safety;

(b) Applies to a division, unit, office, branch or other smaller part of the state agency if the director determines the exception is necessary to allow the state agency to maintain public or state agency employee safety or because of the geographic location of the division, unit, office, branch or other smaller part of the state agency; or

(c) The director determines is warranted because the state agency has supervisory employees exercising authority over personnel who are not employees of the state agency, the state agency has a significant number of part-time or seasonal employees or the state agency has another unique personnel need.

(5) Not later than five business days before the director proposes to grant an exception under this section, the director shall notify each collective bargaining agent of the public or state agency employees in the appropriate bargaining unit for the state agency requesting an exception.

(6) The department shall report all exceptions granted under this [*subsection*] **section** to the Joint Committee on Ways and Means, the Joint Interim Committee on Ways and Means or the Emergency Board.

(7) As used in this section:

(a)(A) "State agency" means all state officers, boards, commissions, departments, institutions, branches, agencies, divisions and other entities, without regard to the designation given to those entities, that are within the executive branch of government as described in Article III, section 1, of the Oregon Constitution.

(B) "State agency" does not include:

(i) The legislative department as defined in ORS 174.114;

(ii) The judicial department as defined in ORS 174.113;

(iii) The Public Defense Services Commission;

(iv) The Secretary of State and the State Treasurer in the performance of the duties of their constitutional offices;

(v) Semi-independent state agencies listed in ORS 182.454;

(vi) The Oregon Tourism Commission;

(vii) The Oregon Film and Video Office;

(viii) The Oregon University System;

(ix) The Oregon Health and Science University;

(x) The Travel Information Council;

(xi) Oregon Corrections Enterprises;

(xii) The Oregon State Lottery Commission;

(xiii) The State Accident Insurance Fund Corporation;

[*(xiv) The Oregon Health Insurance Exchange Corporation;*]

[*(xv)*] **(xiv)** The Oregon Utility Notification Center;

[*(xvi)*] **(xv)** Oregon Community Power;

[*(xvii)*] **(xvi)** The Citizens' Utility Board;

[*(xviii)*] **(xvii)** A special government body as defined in ORS 174.117;

[*(xix)*] **(xviii)** Any other public corporation created under a statute of this state and specifically designated as a public corporation; and

[*(xx)*] **(xix)** Any other semi-independent state agency denominated by statute as a semi-independent state agency.

(b) "Supervisory employee" has the meaning given that term in ORS 243.650.

SECTION 41. 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 [*Oregon Health Insurance Exchange Corporation*] **Department of Consumer and Business Services, the United States Department of Health and Human Ser-**

vices or the Internal Revenue Service as necessary for the [*corporation to determine*] **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 [*corporation*] **Department of Consumer and Business Services** an application and any verification that was submitted to the [*corporation*] **Department of Consumer and Business Services** by an applicant or on behalf of an applicant [*for the determination of*] **in order for the Department of Human Services or the authority to determine the applicant's** eligibility for medical assistance.

SECTION 42. ORS 413.011 is amended to read:

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

(a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS 413.032 and all of the authority's departmental divisions.

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

(e) 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 [*Oregon*] 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.

(C) The implementation of a system of interoperable electronic health records utilized by all health care providers in this state.

(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.

(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 43. ORS 413.017 is amended to read:

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

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

(A) The Public Employees' Benefit Board.

(B) The Oregon Educators Benefit Board.

(C) Trustees of the Public Employees Retirement System.

(D) A city government.

(E) A county government.

(F) A special district.

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

(b) The Public Health Benefit Purchasers Committee shall:

(A) Identify and make specific recommendations to achieve uniformity across all public health

benefit plan designs based on the best available clinical evidence, recognized best practices for health promotion and disease management, demonstrated cost-effectiveness and shared demographics among the enrollees within the pools covered by the benefit plans.

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

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

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

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

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

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

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

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

SECTION 44. ORS 413.085 is amended to read:

413.085. The Director of Human Services, the [*executive director of the Oregon Health Insurance Exchange Corporation*] **Director of the Department of Consumer and Business Services** and the Director of the Oregon Health Authority may delegate to each other by interagency agreement any duties, functions or powers granted to the Department of Human Services, the [*corporation*] **Department of Consumer and Business Services** or the Oregon Health Authority by law, as the directors deem necessary for the efficient and effective operation of the respective functions of the [*department, the corporation*] **departments** and the authority.

SECTION 45. 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) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

(3) "Community health worker" means an individual 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.

(4) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.625.

(5) "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.

(6) "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.

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

[*(7)*] **(8)** "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 Evidence 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 certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical 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.

[*(8)*] **(9)** "Income" has the meaning given that term in ORS 411.704.

[*(9)*] **(10)** "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.

[*(10)*] **(11)** "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 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.

[*(11)*] **(12)** "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

[*(12)*] **(13)** "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.

[*(13)*] **(14)** "Peer wellness specialist" means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health and wellness.

[*(14)*] **(15)** "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.

[*(15)*] **(16)** "Personal health navigator" means an individual 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.

[*(16)*] **(17)** "Quality measure" means the measures and benchmarks identified by the authority in accordance with ORS 414.638.

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

SECTION 46. ORS 414.736 is amended to read:

414.736. As used in ORS 192.493, this chapter[,] **and** ORS chapter 416 [*and section 9, chapter 867, Oregon Laws 2009*]:

(1) "Designated area" means a geographic area of the state defined by the Oregon Health Authority by rule that is served by a prepaid managed care health services organization.

(2) "Fully capitated health plan" means an organization that contracts with the authority on a prepaid capitated basis under ORS 414.618.

(3) "Physician care organization" means an organization that contracts with the authority on a prepaid capitated basis under ORS 414.618 to provide the health services described in ORS 414.025 [*(7)(b)*] **(8)(b)**, (c), (d), (e), (f), (g) and (j). A physician care organization may also contract with the authority on a prepaid capitated basis to provide the health services described in ORS 414.025 [*(7)(k)*] **(8)(k)** and (L).

(4) "Prepaid managed care health services organization" means a managed physical health, dental, mental health or chemical dependency organization that contracts with the authority on a prepaid capitated basis under ORS 414.618. A prepaid managed care health services organization may be a dental care organization, fully capitated health plan, physician care organization, mental health organization or chemical dependency organization.

SECTION 47. ORS 414.740 is amended to read:

414.740. (1) Notwithstanding ORS 414.738 (1), the Oregon Health Authority shall contract under ORS 414.651 with a prepaid group practice health plan that serves at least 200,000 members in this state and that has been issued a certificate of authority by the Department of Consumer and Business Services as a health care service contractor to provide health services as described in ORS 414.025 [*(7)(b)*] **(8)(b)**, (c), (d), (e), (g) and (j). A health plan may also contract with the authority on a prepaid capitated basis to provide the health services described in ORS 414.025 [*(7)(k)*] **(8)(k)** and (L). The authority may accept financial contributions from any public or private entity to help implement and administer the contract. The authority shall seek federal matching funds for any financial contributions received under this section.

(2) In a designated area, in addition to the contract described in subsection (1) of this section, the authority shall contract with prepaid managed care health services organizations to provide health services under ORS 414.631, 414.651 and 414.688 to 414.745.

SECTION 48. ORS 414.826 is amended to read:

414.826. (1) As used in this section:

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

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

(c) "Health benefit plan" has the meaning given that term in ORS 743.730.

(2) The Oregon Health Authority shall administer a private health option to expand access to private health insurance for Oregon's children.

(3) The authority shall adopt by rule criteria for health benefit plans to qualify for premium assistance under the private health option. The criteria may include, but are not limited to, the following:

(a) The health benefit plan offers a benefit package comparable to the health services provided to children receiving medical assistance, including mental health, vision and dental services, and without any exclusion of or delay of coverage for preexisting conditions.

(b) The health benefit plan imposes copayments or other cost sharing that is based upon a family's ability to pay.

(c) Expenditures for the health benefit plan qualify for federal financial participation.

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

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

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

(5) The amount of premium assistance provided under this section shall be:

(a) Equal to the full cost of the premiums for a health benefit plan and a dental plan for children whose family income is at or below 200 percent of the federal poverty guidelines and who have access to employer sponsored health insurance; and

(b) Based on a sliding scale under criteria established by the authority by rule for children whose family income is above 200 percent but at or below 300 percent of the federal poverty guidelines, regardless of whether the child has access to coverage under an employer sponsored health benefit plan or dental plan.

(6) Premium assistance may be available under this section to a child described in subsection (5)(b) of this section for a health benefit plan purchased through the [*Oregon*] health insurance exchange.

SECTION 49. ORS 659A.200, as amended by section 2, chapter 78, Oregon Laws 2014, is amended to read:

659A.200. As used in ORS 659A.200 to 659A.224:

(1) "Disciplinary action" includes but is not limited to any discrimination, dismissal, demotion, transfer, reassignment, supervisory reprimand, warning of possible dismissal or withholding of work, whether or not the action affects or will affect employee compensation.

(2) "Employee" means a person:

(a) Employed by or under contract with the state or any agency of or political subdivision in the state;

(b) Employed by or under contract with any person authorized to act on behalf of the state, or agency of the state or subdivision in the state, with respect to control, management or supervision of any employee;

(c) Employed by the public corporation created under ORS 656.751;

[*(d) Employed by the public corporation established under ORS 741.001;*]

[*(e)*] **(d)** Employed by a contractor who performs services for the state, agency or subdivision, other than employees of a contractor under contract to construct a public improvement; and

[*(f)*] **(e)** Employed by or under contract with any person authorized by contract to act on behalf of the state, agency or subdivision.

(3) "Public employer" means:

(a) The state or any agency of or political subdivision in the state; and

(b) Any person authorized to act on behalf of the state, or any agency of or political subdivision in the state, with respect to control, management or supervision of any employee.

SECTION 50. ORS 743.730 is amended to read:

743.730. For purposes of ORS 743.730 to 743.773:

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

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

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

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee;

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

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

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

(4) "Bona fide association" means an association that:

(a) Has been in active existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

(f) Has a constitution and bylaws; and

(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

(5) "Carrier" means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

[*(6) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon health insurance exchange.*]

[*(7)*] **(6)** "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the enrollee obtains new coverage.

[*(8)*] **(7)** "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

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

[*(10)*] **(9)** "Employee" means any individual employed by an employer.

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

[*(12)*] **(11)** "Exchange" means [*the health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310*] **an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041**.

[*(13)*] **(12)** "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

[*(14)*] **(13)** "Financial impairment" means that a carrier is not insolvent and is:

(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

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

[*(15)(a)*] **(14)(a)** "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

(A) Group health benefit plans offered to small employers; or

(B) Individual health benefit plans.

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

[*(16)*] **(15)** "Grandfathered health plan" has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

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

[*(18)(a)*] **(17)(a)** "Health benefit plan" means any:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Health care service contractor or health maintenance organization subscriber contract; or

(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

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

[*(20)*] **(19)** "Individual health benefit plan" means a health benefit plan:

(a) That is issued to an individual policyholder; or

(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

[*(21)*] **(20)** "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

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

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer and Business Services;

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

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

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

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

[*(23) "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.*]

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

[*(25)*] **(23)** "Preexisting condition exclusion" means:

(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

(b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of this paragraph pregnancy and genetic information do not constitute preexisting conditions.

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

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

[*(28)*] **(26)** "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

[*(29)(a)*] **(27)(a)** "Small employer" means an employer that employed an average of at least one but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least one eligible employee on the first day of the plan year.

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

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

SECTION 51. ORS 743.730, as amended by section 59, chapter 681, Oregon Laws 2013, is amended to read:

743.730. For purposes of ORS 743.730 to 743.773:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743.736 based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions

and methods used by the carrier in establishing premium rates for small employer health benefit plans.

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

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

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee;

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

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

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

(4) "Bona fide association" means an association that:

(a) Has been in active existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

(f) Has a constitution and bylaws; and

(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

(5) "Carrier" means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

[*(6) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon health insurance exchange.*]

[*(7)*] **(6)** "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the enrollee obtains new coverage.

[*(8)*] **(7)** "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

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

[*(10)*] **(9)** "Employee" means any individual employed by an employer.

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

[*(12)*] **(11)** "Exchange" means [*the health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310*] **an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041**.

[*(13)*] **(12)** "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

[*(14)*] **(13)** "Financial impairment" means that a carrier is not insolvent and is:

(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

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

[*(15)(a)*] **(14)(a)** "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

(A) Group health benefit plans offered to small employers; or

(B) Individual health benefit plans.

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

[*(16)*] **(15)** "Grandfathered health plan" has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

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

[*(18)(a)*] **(17)(a)** "Health benefit plan" means any:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Health care service contractor or health maintenance organization subscriber contract; or

(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nurs-

ing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

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

[*(20)*] **(19)** "Individual health benefit plan" means a health benefit plan:

(a) That is issued to an individual policyholder; or

(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

[*(21)*] **(20)** "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

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

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer and Business Services;

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

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

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

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

[*(23) "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.*]

[*(24)*] **(22)** "Multiple employer welfare arrangement" means a multiple employer welfare ar-

rangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

[*(25)*] **(23)** "Preexisting condition exclusion" means:

(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

(b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of this paragraph pregnancy and genetic information do not constitute preexisting conditions.

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

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

[*(28)*] **(26)** "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

[*(29)(a)*] **(27)(a)** "Small employer" means an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least one eligible employee on the first day of the plan year.

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

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

SECTION 52. ORS 743.733 is amended to read:

743.733. (1) If an affiliated group of employers is treated as a single employer under section 414 (b), (c), (m) or (o) of the Internal Revenue Code of 1986, a carrier may issue a single group health benefit plan to the affiliated group on the basis of the number of employees in the affiliated group if the group requests such coverage.

(2) Subsequent to the issuance of a health benefit plan to a small employer, other than a plan issued through the [*Oregon*] health insurance exchange, a carrier shall determine annually the number of employees of the employer for purposes of determining the employer's ongoing eligibility as a small employer.

(3)(a) ORS 743.733 to 743.737 shall continue to apply to a health benefit plan issued outside of the exchange to a small employer until the plan anniversary date following the date the employer no longer meets the definition of a small employer.

(b) ORS 743.733 to 743.737 shall continue to apply to an employer that receives coverage through the exchange until the employer no longer receives coverage through the exchange and is no longer a small employer.

SECTION 53. ORS 743.822 is amended to read:

743.822. (1) In each individual or small group market, in which a carrier offers a health benefit plan through or outside of the [*Oregon*] health insurance exchange **described in ORS 741.310**, the carrier must offer to residents of this state a bronze and a silver plan [*approved*] **certified** by the Department of Consumer and Business Services as **qualified health plans and** meeting the requirements of subsection (2) of this section.

(2) The department shall prescribe by rule**, in accordance with federal requirements,** the form, level of coverage and benefit design for the bronze and silver plans that must be offered under subsection (1) of this section.

(3) As used in this section, "health benefit plan" has the meaning given that term in ORS 743.730.

SECTION 54. ORS 743.826 is amended to read:

743.826. **(1) As used in this section:**

(a) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e).

(b) "Minimum essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

(2) A carrier may offer a catastrophic plan [*only through the exchange and*] only to an individual who:

[*(1)*] **(a)** Is under 30 years of age at the beginning of the plan year; or

[*(2)*] **(b)** Is exempt from any state or federal penalties imposed for failing to maintain [*minimal*] **minimum** essential coverage during the plan year.

SECTION 55. Section 11, chapter 8, Oregon Laws 2012, as amended by section 2, chapter 368, Oregon Laws 2013, is amended to read:

Sec. 11. In each calendar quarter, the Oregon Health Authority shall report to the appropriate committees or interim committees of the Legislative Assembly:

(1) On the implementation of the Oregon Integrated and Coordinated Care Delivery System;

(2) On the progress in implementing an arbitration process in accordance with ORS 414.635 (7);

(3) For the purpose of developing a baseline with which to compare future costs, per member costs for each category of service;

(4) The administrative costs to the authority in the implementation of the system and the aggregate financial information reported to the authority by coordinated care organizations, including but not limited to the coordinated care organizations':

(a) Payments for each category of service as prescribed by the authority; and

(b) Reserves, projected cash flows and other financial information prescribed by the authority by rule; [*and*]

(5) On efforts made, in collaboration with the [*Oregon Health Insurance Exchange Corporation*] **Department of Consumer and Business Services and the United States Department of Health and Human Services**, to coordinate eligibility determination and enrollment processes for qualified health plans and the state medical assistance program**; and**

(6) On the transfer of the information technology for the state medical assistance program from the health insurance exchange to the authority.

SECTION 56. Section 1, chapter 712, Oregon Laws 2013, is amended to read:

Sec. 1. (1) The Legislative Assembly finds that the best system for the delivery and financing of health care in this state will be the system that:

(a) Provides universal access to comprehensive care at the appropriate time.

(b) Ensures transparency and accountability.

(c) Enhances primary care.

(d) Allows the choice of health care provider.

(e) Respects the primacy of the patient-provider relationship.

(f) Provides for continuous improvement of health care quality and safety.

(g) Reduces administrative costs.

(h) Has financing that is sufficient, fair and sustainable.

(i) Ensures adequate compensation of health care providers.

(j) Incorporates community-based systems.

(k) Includes effective cost controls.

(L) Provides universal access to care even if the person is outside of Oregon.

(m) Provides seamless birth-to-death access to care.

(n) Minimizes medical errors.

(o) Focuses on preventative health care.

(p) Integrates physical, dental, vision and mental health care.

(q) Includes long term care.

(r) Provides equitable access to health care, according to a person's needs.

(s) Is affordable for individuals, families, businesses and society.

(2) To the extent practicable using only the funds received under section 2**,** [*of this 2013 Act*] **chapter 712, Oregon Laws 2013**, the Oregon Health Authority shall contract with a third party to conduct a study overseen by the authority to examine at least four options for financing health care delivery in this state, including:

(a) An option for a publicly financed single-payer model for financing privately delivered health care, that is decoupled from employment and allows commercial insurance coverage only of supplemental health services not paid for under the option.

(b) An option that allows a person to choose between a publicly funded plan, including a basic health program under 42 U.S.C. 18051, and private insurance coverage and allows for fair and robust competition among public plans and private insurance.

(c) The current health care financing system in this state, including the:

(A) Oregon Integrated and Coordinated Health Care Delivery System;

(B) [*Oregon*] Health insurance exchange; and

(C) Full implementation of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act (P.L. 111-152) and other subsequent amendments.

(d) An option for a plan that provides essential health benefits, including preventive care and hospital services, and that:

(A) Allows a person to access the commercial market to purchase coverage that is not covered under the plan;

(B) Limits the role of the plan to collecting and distributing revenue while preserving private sector delivery options and optimizing consumer choice;

(C) Offers to Oregonians who earn more than 400 percent of the federal poverty guidelines a deductible plan that could be contributed to by employees and employers;

(D) Exempts Oregonians who earn no more than 400 percent of the federal poverty guidelines from deductibles;

(E) Accesses all sources of available federal funding; and

(F) Identifies program savings that can be achieved by providing health care coverage to all Oregonians, including but not limited to using the program to replace the state medical assistance program and the medical portion of worker's compensation, then applies the savings to finance the plan.

(3) The researchers conducting the study shall review and consider:

(a) Previous studies in this state of alternative models of health care financing or delivery.

(b) Studies of health care financing and delivery systems in other states and countries.

(c) This state's current health care reform efforts.

(d) The impact on and interplay with each option of all of the following:

(A) The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act (P.L. 111-152) and other subsequent amendments;

(B) The Employee Retirement Income Security Act of 1974; and

(C) Titles XVIII, XIX and XXI of the Social Security Act.

(4) The contractor shall prepare a report that summarizes the findings of the study and:

(a) Analyzes the costs and benefits of requiring copayments and of not requiring copayments.

(b) Describes options for health care financing by a government agency, by commercial insurance and by a combination of both government and commercial insurance.

(c) For each option:

(A) Evaluates the extent to which the option satisfies the criteria described in subsection (1) of this section;

(B) Estimates the cost of implementation, including anticipated costs from increased services, more patients, new facilities and savings from efficiencies;

(C) Assesses the impact of implementation on the existing commercial insurance and publicly funded health care systems;

(D) Estimates the net fiscal impact of implementation on individuals and businesses including the tax implications;

(E) Assesses the impact of implementation on the economy of this state; and

(F) Estimates the potential savings to local governments and government agencies that currently administer health care programs, provide health care premium subsidies or provide funding for health care services.

(5) The report must include a recommendation for the option for health care delivery and financing that best satisfies the criteria described in subsection (1) of this section and that:

(a) Maximizes available federal funding; and

(b) Ensures that health care providers receive adequate compensation for providing health care.

UNIT CAPTIONS

SECTION 57. The unit captions used in this 2015 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 2015 Act.

REPEALS

SECTION 58. (1) ORS 741.025, 741.027, 741.029, 741.031 and 741.250 and section 2, chapter 74, Oregon Laws 2014, are repealed.

(2) Section 27, chapter 415, Oregon Laws 2011, as amended by section 8, chapter 38, Oregon Laws 2012, is repealed.

SECTION 59. ORS 741.101 is repealed.

OPERATIVE DATE

SECTION 60. (1) Sections 2 to 4, 7, 9, 10, 12, 13, 27, 35 and 36 of this 2015 Act, the amendments to ORS 243.142, 243.886, 291.229, 291.231, 411.400, 413.011, 413.017, 414.025, 414.736, 414.740, 414.826, 659A.200, 741.002, 741.105, 741.220, 741.222, 741.300, 741.310, 741.381, 741.390, 741.400, 741.500, 741.510, 741.540, 743.730, 743.733, 743.822 and 743.826 and section 11, chapter 8, Oregon Laws 2012, and section 1, chapter 712, Oregon Laws 2013, by sections 17, 18, 20 to 22, 24 to 26, 28 to 31, 33, 37 to 43 and 45 to 56 of this 2015 Act and the repeal of ORS 741.101 by section 59 of this 2015 Act become operative on June 30, 2015.

(2) The amendments to section 14 of this 2015 Act by section 15 of this 2015 Act become operative on January 1, 2016.

EMERGENCY CLAUSE

SECTION 61. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.