(Including Amendments to Resolve Conflicts)

A-Engrossed
Senate Bill 303

Ordered by the House July 29
Including House Amendments dated July 29

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senator Kate Brown for Governor Theodore R. Kulongoski)

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.

Creates Office of Private Health Partnerships. Transfers functions and duties of Insurance Pool Governing Board to Office of Private Health Partnerships. Abolishes Insurance Pool Governing Board.

Permits office to establish by rule procedure for publication or release of aggregate data [*of applicants for enrollment and persons enrolled in Family Health Insurance Assistance Program*] **relating to programs operated by office**.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to Insurance Pool Governing Board; creating new provisions; amending ORS 291.055, 414.831, 735.700, 735.702, 735.706, 735.710, 735.712, 735.714, 735.720, 735.722, 735.724, 735.726, 735.728, 735.730, 735.731, 735.732, 735.733, 735.734, 735.736, 735.740, 735.750, 735.754 and 743.730 and sections 2b and 5, chapter 742, Oregon Laws 2003, and sections 11 and 12, chapter ___, Oregon Laws 2005 (Enrolled House Bill 2062); repealing ORS 735.704 and 735.708 and section 5, chapter 238, Oregon Laws 2005 (Enrolled House Bill 2063), and section 5, chapter 262, Oregon Laws 2005 (Enrolled House Bill 2064); and declaring an emergency.

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

SECTION 1. (1) The Insurance Pool Governing Board established by ORS 735.704 is abolished. On the operative date of this section, the tenure of office of the members of the Insurance Pool Governing Board ceases.

(2) The duties, functions and powers of the Insurance Pool Governing Board relating to health insurance and health care are imposed upon, transferred to and vested in the Office of Private Health Partnerships.

SECTION 2. (1) The Office of Private Health Partnerships is established.

(2) The office shall carry out the duties described under ORS 414.831, 735.700 to 735.714 and 735.720 to 735.740.

SECTION 3. (1) The Office of Private Health Partnerships is under the supervision and control of an administrator, who is responsible for the performance of the duties, functions and powers of the office.

(2) The Governor shall appoint the Administrator of the Office of Private Health Partnerships, who holds office at the pleasure of the Governor.

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.

(3) The administrator shall be paid a salary as provided by law or, if not so provided, as prescribed by the Governor.

(4) For purposes of administration, subject to the approval of the Governor, the administrator may organize and reorganize the office as the administrator considers necessary to properly conduct the work of the office.

SECTION 4. (1) The Administrator of the Office of Private Health Partnerships shall, by written order filed with the Secretary of State, appoint a deputy director. The deputy director serves at the pleasure of the administrator, has authority to act for the administrator in the absence of the administrator and is subject to the control of the administrator at all times.

(2) Subject to any applicable provisions of ORS chapter 240, the administrator shall appoint all subordinate officers and employees of the Office of Private Health Partnerships, prescribe their duties and fix their compensation.

SECTION 5. In accordance with applicable provisions of ORS chapter 183, the Administrator of the Office of Private Health Partnerships may adopt rules necessary for the administration of the laws that the Office of Private Health Partnerships is charged with administering.

SECTION 6. (1) The Insurance Pool Governing Board shall:

(a) Deliver to the Office of Private Health Partnerships all records and property within the jurisdiction of the board that relate to the duties, functions and powers transferred by section 1 of this 2005 Act; and

(b) Transfer to the Office of Private Health Partnerships those employees engaged primarily in the exercise of the duties, functions and powers transferred by section 1 of this 2005 Act.

(2) The Administrator of the Office of Private Health Partnerships shall take possession of the records and property, and shall take charge of the employees and employ them in the exercise of the duties, functions and powers transferred by section 1 of this 2005 Act, without reduction of compensation but subject to change or termination of employment or compensation as provided by law.

(3) The Governor shall resolve any dispute between the Insurance Pool Governing Board and the Office of Private Health Partnerships relating to transfers of records, property and employees under this section, and the Governor's decision is final.

SECTION 7. (1) The unexpended balances of amounts authorized to be expended by the Insurance Pool Governing Board for the biennium beginning July 1, 2005, from revenues dedicated, continuously appropriated, appropriated or otherwise made available for the purpose of administering and enforcing the duties, functions and powers transferred by section 1 of this 2005 Act are appropriated and transferred to and are available for expenditure by the Office of Private Health Partnerships for the biennium beginning July 1, 2005, for the purpose of administering and enforcing the duties, functions and powers transferred by section 1 of this 2005 Act.

(2) The expenditure classifications, if any, established by Acts authorizing or limiting expenditures by the Insurance Pool Governing Board remain applicable to expenditures by the Office of Private Health Partnerships under this section.

SECTION 8. The transfer of duties, functions and powers to the Office of Private Health Partnerships by section 1 of this 2005 Act does not affect any action, proceeding or prose-

cution involving or with respect to such duties, functions and powers begun before and pending at the time of the transfer, except that the Office of Private Health Partnerships is substituted for the Insurance Pool Governing Board in the action, proceeding or prosecution.

SECTION 9. (1) Nothing in sections 1, 6, 7 and 8 of this 2005 Act relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions and powers transferred by section 1 of this 2005 Act. The Office of Private Health Partnerships may undertake the collection or enforcement of any such liability, duty or obligation.

(2) The rights and obligations of the Insurance Pool Governing Board legally incurred under contracts, leases and business transactions executed, entered into or begun before the operative date of section 1 of this 2005 Act accruing under or with respect to the duties, functions and powers transferred by section 1 of this 2005 Act are transferred to the Office of Private Health Partnerships. For the purpose of succession to these rights and obligations, the Office of Private Health Partnerships is a continuation of the Insurance Pool Governing Board and not a new authority.

SECTION 10. (1) To aid and advise the Administrator of the Office of Private Health Partnerships in the performance of the functions of the Office of Private Health Partnerships, the administrator may establish advisory committees that the administrator considers necessary. These committees may be continuing or temporary. The administrator shall determine the representation, membership, terms and organization of the committees and shall appoint their members. The administrator is an ex officio member of each committee.

(2) Members appointed to the committees shall represent business, labor, employers, insurance carriers or producers and consumers.

(3) Members of the committees are not entitled to compensation, but at the discretion of the administrator may be reimbursed from funds available to the office for actual and necessary travel and other expenses incurred in the performance of their official duties in the manner and amount provided in ORS 292.495.

SECTION 11. Notwithstanding the transfer of duties, functions and powers by section 1 of this 2005 Act, the rules of the Insurance Pool Governing Board with respect to such duties, functions or powers that are in effect on the operative date of section 1 of this 2005 Act continue in effect until superseded or repealed by rules of the Office of Private Health Partnerships. References in such rules of the Insurance Pool Governing Board to the Insurance Pool Governing Board or an officer or employee of the Insurance Pool Governing Board are considered to be references to the Office of Private Health Partnerships or an officer or employee of the Office of Private Health Partnerships.

SECTION 12. Whenever, in any uncodified law or resolution of the Legislative Assembly or in any rule, document, record or proceeding authorized by the Legislative Assembly, in the context of the duties, functions and powers transferred by section 1 of this 2005 Act, reference is made to the Insurance Pool Governing Board, or an officer or employee of the Insurance Pool Governing Board whose duties, functions or powers are transferred by section 1 of this 2005 Act, the reference is considered to be a reference to the Office of Private Health Partnerships or an officer or employee of the Office of Private Health Partnerships who by this 2005 Act is charged with carrying out such duties, functions and powers.

SECTION 13. (1) The Governor shall appoint the Administrator of the Office of Private Health Partnerships on or before November 1, 2005.

(2) The administrator may take any action before the operative date of section 1 of this

2005 Act that is necessary to enable the administrator to exercise, on and after the operative date of section 1 of this 2005 Act, the duties, functions and powers of the administrator pursuant to section 1 of this 2005 Act.

SECTION 14. ORS 735.700 is amended to read:

735.700. As used in ORS 735.700 to [*735.740*] **735.714**, unless the context requires otherwise:

[*(1) "Board" means the Insurance Pool Governing Board established under ORS 735.704.*]

[*(2)*] **(1)** "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation.

[*(3) "Class of employee" means an employee classed as either management or nonmanagement employee.*]

[*(4)*] **(2)** "Eligible employee" means an employee of an employer who is employed by the employer for an average of at least 17.5 hours per week, sole proprietors, business partners, and limited partners. The term does not include individuals:

(a) Engaged as independent contractors.

(b) Whose periods of employment are on an intermittent or irregular basis.

[*(5)*] **(3)** "Family member" means an eligible employee's spouse, any unmarried child or stepchild within age limits and other conditions imposed by the [*board*] **Office of Private Health Partnerships** with regard to unmarried children or stepchildren, or any other dependents eligible under the terms of the health benefit plan selected by the employee's employer.

[*(6)*] **(4)** "Health benefit plan" means a contract for group medical, surgical, hospital or any other remedial care recognized by state law and related services and supplies.

[*(7)*] **(5)** "Premium" means the monthly or other periodic charge for a health benefit plan.

SECTION 15. ORS 735.700, as amended by section 6, chapter 742, Oregon Laws 2003, is amended to read:

735.700. As used in ORS 735.700 to [*735.740*] **735.714**, unless the context requires otherwise:

[*(1) "Board" means the Insurance Pool Governing Board established under ORS 735.704.*]

[*(2)*] **(1)** "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation.

[*(3) "Class of employee" means an employee classed as either management or nonmanagement employee.*]

[*(4)*] **(2)** "Eligible employee" means an employee of an employer who is employed by the employer for an average of at least 17.5 hours per week who elects to participate in one of the group benefit plans provided through [*board*] action **of the Office of Private Health Partnerships**, and sole proprietors, business partners, and limited partners. The term does not include individuals:

(a) Engaged as independent contractors.

(b) Whose periods of employment are on an intermittent or irregular basis.

(c) Who have been employed by the employer for fewer than 90 days.

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

[*(6)*] **(4)** "Health benefit plan" means a contract for group medical, surgical, hospital or any

other remedial care recognized by state law and related services and supplies.

[*(7)*] **(5)** "Premium" means the monthly or other periodic charge for a health benefit plan.

SECTION 16. ORS 735.702 is amended to read:

735.702. To increase access to health insurance and health care, the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall provide:

(1) Information about health benefit plans and the premiums charged for those plans to self-employed individuals and small employers in Oregon;

(2) Direct assistance to health insurance producers and health insurance consumers regarding health benefit plans;

(3) A central source for information about resources for health care and health insurance; and

(4) Health benefit plans for small employers.

SECTION 17. ORS 735.702, as amended by section 7, chapter 742, Oregon Laws 2003, is amended to read:

735.702. To increase access to health insurance and health care, the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall provide:

(1) Information about health benefit plans and the premiums charged for those plans to self-employed individuals and small employers in Oregon;

(2) Direct assistance to health insurance producers and health insurance consumers regarding health benefit plans;

(3) A central source for information about resources for health care and health insurance; and

(4) Health benefit plans for small employers that have not provided a group health benefit plan for eligible employees for a period of at least one year.

SECTION 18. ORS 735.706 is amended to read:

735.706. The [*Insurance Pool Governing Board Account*] **Office of Private Health Partnerships Account** is established separate and distinct from the General Fund. All moneys received by the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships**, other than appropriations from the General Fund and except for moneys in the account established by ORS 735.736, shall be deposited into the account and are continuously appropriated to the [*board*] **office** to carry out the duties, functions and powers of the [*board*] **office**.

SECTION 19. ORS 735.710 is amended to read:

735.710. (1) In carrying out its duties under ORS 735.700 to **735.714 and 735.720 to** 735.740, the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** may:

(a) Enter into contracts for administration of ORS 735.700 to **735.714 and 735.720 to** 735.740**,** including collection of premiums and paying carriers.

(b) Retain consultants and employ staff.

(c) Enter into contracts with carriers or health care providers for health benefit plans.

(d) Set premium rates for eligible employees and small employers.

(e) Perform other duties to provide low-cost health benefit plans of types likely to be purchased by small employers.

(f) Establish contributions to be paid by small employers toward the premiums incurred on behalf of covered eligible employees.

(g) Establish procedures by rule for the publication or release of aggregate data relating to:

(A) Applicants for enrollment and persons enrolled in the Family Health Insurance Assistance Program;

(B) Health benefit plans for small employers offered by the office; and

(C) Other programs operated by the office.

(2) Notwithstanding any other health benefit plan contracted for and offered by the [*board*] **office**, the [*board*] **office** shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees and small employers.

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

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

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

(6) Transfer of enrollment from one health benefit plan to another shall be open to all eligible employees and family members under rules adopted by the [*board*] **office**.

(7) If the [*board*] **office** requests less health care service or benefit than is otherwise required by state law, a carrier is not required to offer such service or benefit.

(8) The [*board*] **office** may contract for and offer health benefit plans for small employers that provide a sufficient level of benefits to be eligible for a subsidy under ORS 735.724 as well as health benefit plans for small employers that are not eligible for a subsidy under ORS 735.724.

(9) The [*board*] **office** may employ whatever means are reasonably necessary to carry out the purposes of ORS 735.700 to **735.714 and 735.720 to** 735.740. Such authority includes but is not limited to authority to seek clarification, amendment, modification, suspension or termination of any agreement or contract [*which*] **that** in the [*board's*] **office's** judgment requires such action.

SECTION 20. ORS 735.710, as amended by section 8, chapter 742, Oregon Laws 2003, is amended to read:

735.710. (1) In carrying out its duties under ORS 735.700 to **735.714 and 735.720 to** 735.740, the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall:

(a) Enter into contracts for administration of ORS 735.700 to **735.714 and 735.720 to** 735.740**,** including collection of premiums and paying carriers.

(b) Retain consultants and employ staff.

(c) Enter into contracts with carriers or health care providers for health benefit plans, including contracts where final payment may be reduced if usage is below a level fixed in the contract.

(d) Set premium rates for eligible employees and small employers.

(e) Perform other duties to provide low-cost health benefit plans of types likely to be purchased by small employers.

(f) Establish contributions to be paid by small employers toward the premiums incurred on behalf of covered eligible employees.

(g) Establish procedures by rule for the publication or release of aggregate data relating to:

(A) Applicants for enrollment and persons enrolled in the Family Health Insurance Assistance Program;

(B) Health benefit plans for small employers offered by the office; and

(C) Other programs operated by the office.

(2) Notwithstanding any other health benefit plan contracted for and offered by the [*board*] **of-**

fice, the [*board*] **office** shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees and small employers.

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

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

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

(6) Transfer of enrollment from one health benefit plan to another shall be open to all eligible employees and family members under rules adopted by the [*board*] **office**.

(7) If the [*board*] **office** requests less health care service or benefit than is otherwise required by state law, a carrier is not required to offer such service or benefit.

(8) Health benefit plans for small employers contracted for and offered by the [*board*] **office** must provide a sufficient level of benefits to be eligible for a subsidy under ORS 735.724.

(9) The [*board*] **office** may employ whatever means are reasonably necessary to carry out the purposes of ORS 735.700 to **735.714 and 735.720 to** 735.740. Such authority includes but is not limited to authority to seek clarification, amendment, modification, suspension or termination of any agreement or contract [*which*] **that** in the [*board's*] **office's** judgment requires such action.

SECTION 21. ORS 735.712 is amended to read:

735.712. (1) The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall encourage increased health insurance coverage among small employers:

(a) By providing information, benefit comparisons, premium comparisons and technical assistance on obtaining employee benefits and on incentives including, but not limited to, information on the pretax health benefit options allowed under section 125 of the United States Internal Revenue Code; and

(b) By using other means necessary to market health benefit plan coverage to small employers.

(2) The [*Insurance Pool Governing Board*] **office** shall provide information about other resources for accessing health care and shall assist consumers in accessing those resources.

SECTION 22. ORS 735.714 is amended to read:

735.714. The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** may renew health benefit plans for small employers offered by the [*board*] **office** on or after September 2, 2003, that are not eligible for a subsidy under ORS 735.724.

SECTION 23. ORS 735.720 is amended to read:

735.720. For purposes of ORS 735.720 to 735.740:

(1) "Carrier" has the meaning given that term in ORS 735.700.

[*(1)*] **(2)** "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) Either has been without health benefit plan coverage for a period of time established by the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships**, or meets exception criteria established by the [*board*] **office**;

(d) Except as otherwise provided by the [*board*] **office**, has family income less than 200 percent of the federal poverty level;

(e) Has investments and savings less than the limit established by the [*board*] **office**; and

(f) Meets other eligibility criteria established by the [*board*] **office**.

[*(2)*] **(3)** "Family" means:

(a) A single individual;

(b) An adult and the adult's spouse;

(c) An adult and the adult's spouse, all unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult or the adult's spouse, and all dependent children of a dependent child; or

(d) An adult and the adult's unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult, and all dependent children of a dependent child.

[*(3)(a)*] **(4)(a)** "Health benefit plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement for hospital, medical and surgical expenses. "Health benefit plan" includes a medical savings account, health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital indemnity only, dental only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.

[*(4)*] **(5)** "Income" means gross income in cash or kind available to the applicant or recipient.

[*(5)*] **(6)** "Investment 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 [*board*] **office** may establish that are available to the applicant or recipient to contribute toward meeting the needs of an applicant or eligible individual.

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

[*(7)*] **(8)** "Medical savings account" means a trust that is created exclusively for the purpose of paying qualified medical expenses of the account holder and that qualifies for tax deduction under section 220 of the Internal Revenue Code. "Medical savings account" includes an associated high deductible health benefit plan.

[*(8)*] **(9)** "Resident" means an individual who [*demonstrates to the Insurance Pool Governing Board that the individual is lawfully residing in Oregon and intends to reside in Oregon*] **meets the residency requirements established by rule by the office**.

[*(9)*] **(10)** "Subsidy" means payment or reimbursement to an eligible individual toward the purchase of a health benefit plan, and may include a net billing arrangement with [*insurance*] carriers or a prospective or retrospective payment for health benefit plan premiums and eligible copayments or deductible expenses directly related to the eligible individual.

[*(10)*] **(11)** "Third-party administrator" means any insurance company or other entity licensed under the Insurance Code to administer health insurance benefit programs.

SECTION 23a. Section 5, chapter 238, Oregon Laws 2005 (Enrolled House Bill 2063) (amending ORS 735.720), and section 5, chapter 262, Oregon Laws 2005 (Enrolled House Bill 2064) (amending ORS 735.720), are repealed.

SECTION 23b. If House Bill 2062 does not become law, ORS 735.720, as amended by section 23 of this 2005 Act, is amended to read:

735.720. For purposes of ORS 735.720 to 735.740:

(1) "Carrier" has the meaning given that term in ORS 735.700.

(2) "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) Either has been without health benefit plan coverage for a period of time established by the Office of Private Health Partnerships, or meets exception criteria established by the office;

(d) Except as otherwise provided by the office, has family income less than 200 percent of the federal poverty level;

(e) Has investments and savings less than the limit established by the office; and

(f) Meets other eligibility criteria established by the office.

(3)**(a)** "Family" means:

[*(a)*] **(A)** A single individual;

[*(b)*] **(B)** An adult and the adult's spouse;

[*(c)*] **(C)** An adult and the adult's spouse, all unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult or the adult's spouse, and all dependent children of a dependent child; or

[*(d)*] **(D)** An adult and the adult's unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult, and all dependent children of a dependent child.

(b) A family includes a dependent elderly relative or a dependent adult disabled child who meets the criteria established by the office and who lives in the home of the adult described in paragraph (a) of this subsection.

(4)(a) "Health benefit plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement for hospital, medical and surgical expenses. "Health benefit plan" includes a [*medical savings account,*] health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital indemnity only, dental only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in

Oregon.

(5) "Income" means gross income in cash or kind available to the applicant or [*recipient*] **applicant's family. "Income" does not mean earned income of minor children**.

(6) "Investment 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 office may establish that are available to the applicant or [*recipient*] **applicant's family** to contribute toward meeting the needs of an applicant or eligible individual.

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

[*(8) "Medical savings account" means a trust that is created exclusively for the purpose of paying qualified medical expenses of the account holder and that qualifies for tax deduction under section 220 of the Internal Revenue Code. "Medical savings account" includes an associated high deductible health benefit plan.*]

[*(9)*] **(8)** "Resident" means an individual who meets the residency requirements established by rule by the office.

[*(10)*] **(9)** "Subsidy" means payment or reimbursement to an eligible individual toward the purchase of a health benefit plan, and may include a net billing arrangement with carriers or a prospective or retrospective payment for health benefit plan premiums and eligible copayments or deductible expenses directly related to the eligible individual.

[*(11)*] **(10)** "Third-party administrator" means any insurance company or other entity licensed under the Insurance Code to administer health insurance benefit programs.

SECTION 23c. The amendments to ORS 735.720 by section 23b of this 2005 Act become operative on January 1, 2006.

SECTION 23d. If House Bill 2062 becomes law, section 23 of this 2005 Act (amending ORS 735.720) is repealed and ORS 735.720, as amended by section 5, chapter ___, Oregon Laws 2005 (Enrolled House Bill 2062), is amended to read:

735.720. For purposes of ORS 735.720 to 735.740:

(1) "Carrier" has the meaning given that term in ORS 735.700.

(2) "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) Either has been without health benefit plan coverage for a period of time established by the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships**, or meets exception criteria established by the [*board*] **office**;

(d) Except as otherwise provided by the [*board*] **office**, has family income less than 200 percent of the federal poverty level;

(e) Has investments and savings less than the limit established by the [*board*] **office**; and

(f) Meets other eligibility criteria established by the [*board*] **office**.

(3) "Family" means:

(a) A single individual;

(b) An adult and the adult's spouse;

(c) An adult and the adult's spouse, all unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult or the adult's spouse, and all dependent children of a dependent child; or

(d) An adult and the adult's unmarried, dependent children under 23 years of age, including

adopted children, children placed for adoption and children under the legal guardianship of the adult, and all dependent children of a dependent child.

(4)(a) "Health benefit plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement for hospital, medical and surgical expenses. "Health benefit plan" includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital indemnity only, dental only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.

(5) "Income" means gross income in cash or kind available to the applicant or the applicant's family. Income does not include earned income of the applicant's children or income earned by a spouse if there is a legal separation.

(6) "Investment 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 [*board*] **office** may establish that are available to the applicant or recipient to contribute toward meeting the needs of an applicant or eligible individual.

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

(8) "Resident" means an individual who meets the residency requirements established by rule by the [*Insurance Pool Governing Board*] **office**.

(9) "Subsidy" means payment or reimbursement to an eligible individual toward the purchase of a health benefit plan, and may include a net billing arrangement with carriers or a prospective or retrospective payment for health benefit plan premiums and eligible copayments or deductible expenses directly related to the eligible individual.

(10) "Third-party administrator" means any insurance company or other entity licensed under the Insurance Code to administer health insurance benefit programs.

SECTION 23e. If House Bill 2062 becomes law, ORS 735.720, as amended by section 23d of this 2005 Act, is amended to read:

735.720. For purposes of ORS 735.720 to 735.740:

(1) "Carrier" has the meaning given that term in ORS 735.700.

(2) "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) Either has been without health benefit plan coverage for a period of time established by the Office of Private Health Partnerships, or meets exception criteria established by the office;

(d) Except as otherwise provided by the office, has family income less than 200 percent of the federal poverty level;

(e) Has investments and savings less than the limit established by the office; and

(f) Meets other eligibility criteria established by the office.

(3)**(a)** "Family" means:

[*(a)*] **(A)** A single individual;

[*(b)*] **(B)** An adult and the adult's spouse;

[*(c)*] **(C)** An adult and the adult's spouse, all unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult or the adult's spouse, and all dependent children of a dependent child; or

[*(d)*] **(D)** An adult and the adult's unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult, and all dependent children of a dependent child.

(b) A family includes a dependent elderly relative or a dependent adult disabled child who meets the criteria established by the office and who lives in the home of the adult described in paragraph (a) of this subsection.

(4)(a) "Health benefit plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement for hospital, medical and surgical expenses. "Health benefit plan" includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital indemnity only, dental only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.

(5) "Income" means gross income in cash or kind available to the applicant or the applicant's family. Income does not include earned income of the applicant's children or income earned by a spouse if there is a legal separation.

(6) "Investment 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 office may establish that are available to the applicant or [*recipient*] **the applicant's family** to contribute toward meeting the needs of an applicant or eligible individual.

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

(8) "Resident" means an individual who meets the residency requirements established by rule by the office.

(9) "Subsidy" means payment or reimbursement to an eligible individual toward the purchase of a health benefit plan, and may include a net billing arrangement with carriers or a prospective or retrospective payment for health benefit plan premiums and eligible copayments or deductible expenses directly related to the eligible individual.

(10) "Third-party administrator" means any insurance company or other entity licensed under

the Insurance Code to administer health insurance benefit programs.

SECTION 23f. The amendments to ORS 735.720 by section 23e of this 2005 Act become operative on January 1, 2006.

SECTION 23g. If House Bill 2062 becomes law, ORS 735.720, as amended by section 5a, chapter ___, Oregon Laws 2005 (Enrolled House Bill 2062), is amended to read:

735.720. For purposes of ORS 735.720 to 735.740:

(1) "Carrier" has the meaning given that term in ORS 735.700.

(2) "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) Either has been without health benefit plan coverage for a period of time established by the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships**, or meets exception criteria established by the [*board*] **office**;

(d) Except as otherwise provided by the [*board*] **office**, has family income less than 200 percent of the federal poverty level;

(e) Has investments and savings less than the limit established by the [*board*] **office**; and

(f) Meets other eligibility criteria established by the [*board*] **office**.

(3)(a) "Family" means:

(A) A single individual;

(B) An adult and the adult's spouse;

(C) An adult and the adult's spouse, all unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult or the adult's spouse, and all dependent children of a dependent child; or

(D) An adult and the adult's unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult, and all dependent children of a dependent child.

(b) A family includes a dependent elderly relative or a dependent adult disabled child who meets the criteria established by the [*board*] **office** and who lives in the home of the adult described in paragraph (a) of this subsection.

(4)(a) "Health benefit plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement for hospital, medical and surgical expenses. "Health benefit plan" includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital indemnity only, dental only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.

(5) "Income" means gross income in cash or kind available to the applicant or the applicant's

family. Income does not include earned income of the applicant's children or income earned by a spouse if there is a legal separation.

(6) "Investment 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 [*board*] **office** may establish that are available to the applicant or the applicant's family to contribute toward meeting the needs of an applicant or eligible individual.

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

(8) "Resident" means an individual who meets the residency requirements established by rule by the [*Insurance Pool Governing Board*] **office**.

(9) "Subsidy" means payment or reimbursement to an eligible individual toward the purchase of a health benefit plan, and may include a net billing arrangement with carriers or a prospective or retrospective payment for health benefit plan premiums and eligible copayments or deductible expenses directly related to the eligible individual.

(10) "Third-party administrator" means any insurance company or other entity licensed under the Insurance Code to administer health insurance benefit programs.

SECTION 23h. The amendments to ORS 735.720 by section 23g of this 2005 Act become operative on January 1, 2006.

SECTION 24. ORS 735.722 is amended to read:

735.722. (1) There is established the Family Health Insurance Assistance Program in the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships**. The purpose of the program is to remove economic barriers to health insurance coverage for residents of the State of Oregon with family income less than 200 percent of the federal poverty level, and investment and savings less than the limit established by the [*board*] **office**, while encouraging individual responsibility, promoting health benefit plan coverage of children, building on the private sector health benefit plan system and encouraging employer and employee participation in employer sponsored health benefit plan coverage.

(2) The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall be responsible for the implementation and operation of the Family Health Insurance Assistance Program. The Administrator of the Office for Oregon Health Policy and Research, in consultation with the Oregon Health Policy Commission, shall make recommendations to the [*board*] **Office of Private Health Partnerships** regarding program policy, including but not limited to eligibility requirements, assistance levels, benefit criteria and [*insurance*] carrier participation. The [*board*] **Office of Private Health Partnerships** shall adopt all policy recommendations made by the Administrator of the Office for Oregon Health Policy and Research pursuant to this subsection.

(3) The [*board*] **Office of Private Health Partnerships** may contract with one or more third-party administrators to administer one or more components of the Family Health Insurance Assistance Program. Duties of a third-party administrator may include but are not limited to:

(a) Eligibility determination;

(b) Data collection;

(c) Assistance payments;

(d) Financial tracking and reporting; and

(e) Such other services as the [*board*] **office** may deem necessary for the administration of the program.

(4) If the [*board*] **office** decides to enter into a contract with a third-party administrator pursu-

ant to subsection (3) of this section, the [*board*] **office** shall engage in competitive bidding. The [*board*] **office** shall evaluate bids according to criteria established by the [*board*] **office**, including but not limited to:

(a) The applicant's proven ability to administer a program of the size of the Family Health Insurance Assistance Program;

(b) The efficiency of the applicant's payment procedures;

(c) The estimate provided of the total charges necessary to administer the program; and

(d) The applicant's ability to operate the program in a cost-effective manner.

SECTION 24a. If House Bill 2062 becomes law, section 24 of this 2005 Act (amending ORS 735.722) is repealed and ORS 735.722, as amended by section 6, chapter ___, Oregon Laws 2005 (Enrolled House Bill 2062), is amended to read:

735.722. (1) There is established the Family Health Insurance Assistance Program in the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships**. The purpose of the program is to remove economic barriers to health insurance coverage for residents of the State of Oregon with family income less than 200 percent of the federal poverty level, and investment and savings less than the limit established by the [*board*] **office**, while encouraging individual responsibility, promoting health benefit plan coverage of children, building on the private sector health benefit plan system and encouraging employer and employee participation in employer sponsored health benefit plan coverage.

(2) The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall be responsible for the implementation and operation of the Family Health Insurance Assistance Program. The Administrator of the Office for Oregon Health Policy and Research, in consultation with the Oregon Health Policy Commission, shall make recommendations to the [*board*] **Office of Private Health Partnerships** regarding program policy, including but not limited to eligibility requirements, assistance levels, benefit criteria and carrier participation.

(3) The [*board*] **Office of Private Health Partnerships** may contract with one or more third-party administrators to administer one or more components of the Family Health Insurance Assistance Program. Duties of a third-party administrator may include but are not limited to:

(a) Eligibility determination;

(b) Data collection;

(c) Assistance payments;

(d) Financial tracking and reporting; and

(e) Such other services as the [*board*] **office** may deem necessary for the administration of the program.

(4) If the [*board*] **office** decides to enter into a contract with a third-party administrator pursuant to subsection (3) of this section, the [*board*] **office** shall engage in competitive bidding. The [*board*] **office** shall evaluate bids according to criteria established by the [*board*] **office**, including but not limited to:

(a) The bidder's proven ability to administer a program of the size of the Family Health Insurance Assistance Program;

(b) The efficiency of the bidder's payment procedures;

(c) The estimate provided of the total charges necessary to administer the program; and

(d) The bidder's ability to operate the program in a cost-effective manner.

SECTION 24b. If House Bill 2062 becomes law, section 11, chapter ___, Oregon Laws 2005 (Enrolled House Bill 2062), is amended to read:

Sec. 11. (1) A small employer may obtain a health benefit plan offered by the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** only if the small employer pays a contribution established under ORS 735.710 (1)(f) toward the premium incurred on behalf of a covered eligible employee.

(2) Notwithstanding section 2b, chapter 742, Oregon Laws 2003, the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** may offer a health benefit plan to a small employer that contributed to a health benefit plan solely for the benefit of the employer or the employer's dependents.

SECTION 24c. If House Bill 2062 becomes law, section 12, chapter ___, Oregon Laws 2005 (Enrolled House Bill 2062), is amended to read:

Sec. 12. (1) The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall impose and collect assessments against carriers who have entered into contracts under ORS 735.710 (1)(c) to offer health benefit plans for small employers. The [*board*] **office** shall apply the same assessment rate against all participating carriers.

(2) A carrier's assessment shall be an amount established by rule that is:

(a) Not greater than one percent of the earned premiums a carrier receives from selling health benefit plans to small employers under ORS 735.710 (1)(c); or

(b) A flat rate per small employer health benefit plan sold by a carrier to small employers under ORS 735.710 (1)(c).

(3) A carrier shall pay its assessment as required by the [*board*] **office**.

(4) The [*board*] **office** shall adopt rules to implement this section.

SECTION 24d. If House Bill 2062 becomes law, ORS 291.055, as amended by section 14, chapter ___, Oregon Laws 2005 (Enrolled House Bill 2062), is amended to read:

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

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

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

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

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

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

(2) This section does not apply to:

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

(b) Taxes or other payments made or collected from employers for unemployment insurance required by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

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

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

(C) Copayments and premiums paid to the Oregon medical assistance program.

(D) Assessments paid to the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** under section 12 [*of this 2005 Act*]**, chapter ___, Oregon Laws 2005 (Enrolled House Bill 2062)**.

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

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

(f) Any intergovernmental charges.

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

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

(i) Any charges established by the Oregon State Fair and Exposition Center in accordance with ORS 565.080 (3).

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

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

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

(3)(a) Fees temporarily decreased for competitive or promotional reasons or because of unexpected and temporary revenue surpluses may be restored to their normal level if, at the time the fee is decreased, the state agency specifies the following:

(A) The reason for the fee decrease; and

(B) The conditions under which the fee will be restored to its normal level.

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

SECTION 24e. If House Bill 2062 becomes law, ORS 291.055, as amended by section 14, chapter ___, Oregon Laws 2005 (Enrolled House Bill 2062), and section 24d of this 2005 Act, is amended to read:

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

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

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

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

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

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

(2) This section does not apply to:

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

(b) Taxes or other payments made or collected from employers for unemployment insurance required by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

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

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

(C) Copayments and premiums paid to the Oregon medical assistance program.

[*(D) Assessments paid to the Office of Private Health Partnerships under section 12, chapter ___, Oregon Laws 2005 (Enrolled House Bill 2062).*]

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

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

(f) Any intergovernmental charges.

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

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

(i) Any charges established by the Oregon State Fair and Exposition Center in accordance with ORS 565.080 (3).

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

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

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

(3)(a) Fees temporarily decreased for competitive or promotional reasons or because of unexpected and temporary revenue surpluses may be restored to their normal level if, at the time the fee is decreased, the state agency specifies the following:

(A) The reason for the fee decrease; and

(B) The conditions under which the fee will be restored to its normal level.

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

SECTION 24f. The amendments to ORS 291.055 by section 24e of this 2005 Act become operative on January 2, 2008.

SECTION 25. ORS 735.724 is amended to read:

735.724. (1) To enroll in the Family Health Insurance Assistance Program established in ORS 735.720 to 735.740, an applicant shall submit a written application to the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** or to the third-party administrator contracted by the [*board*] **office** to administer the program pursuant to ORS 735.722 in the form and manner prescribed by the [*board*] **office**. Except as provided in ORS 735.728, if the applicant qualifies as an eligible individual, the applicant shall either be enrolled in the program or placed on a waiting list for enrollment.

(2) After an eligible individual has enrolled in the program, the individual shall remain eligible for enrollment for the period of time established by the [*board*] **office**.

(3) After an eligible individual has enrolled in the program, the [*board*] **office** or third-party administrator shall issue subsidies in an amount determined pursuant to ORS 735.726 to either the eligible individual or to the [*health insurance*] carrier designated by the eligible individual, subject to the following restrictions:

(a) Subsidies may not be issued to an eligible individual unless all children, if any, in the eligible individual's family are covered under a health benefit plan or Medicaid.

(b) Subsidies may not be used to subsidize premiums on a health benefit plan whose premiums are wholly paid by the eligible individual's employer without contribution from the employee.

(c) Such other restrictions as the [*board*] **office** may adopt.

(4) The [*board*] **office** may issue subsidies to an eligible individual in advance of a purchase of a health benefit plan.

(5) To remain eligible for a subsidy, an eligible individual must enroll in a group health benefit plan if a plan is available to the eligible individual through the individual's employment and the employer makes a monetary contribution toward the cost of the plan, unless the [*board*] **office** implements specific cost or benefit structure criteria that make enrollment in an individual health insurance plan more advantageous for the eligible individual.

(6) Notwithstanding ORS 735.720 [*(3)*] **(4)**(b), if an eligible individual is enrolled in a group health benefit plan available to the eligible individual through the individual's employment and the employer requires enrollment in both a health benefit plan and a dental plan, the individual is eligible for a subsidy for both the health benefit plan and the dental plan.

SECTION 26. ORS 735.726 is amended to read:

735.726. (1) The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall determine the level of assistance to be granted under ORS 735.724 based on a sliding scale that considers:

(a) Family size;

(b) Family income;

(c) The number of members of a family who will receive health benefit plan coverage subsidized through the Family Health Insurance Assistance Program; and

(d) Such other factors as the [*board*] **office** may establish.

(2) Notwithstanding the sliding scale established in subsection (1) of this section, the [*board*] **office** may establish different assistance levels for otherwise similarly situated eligible individuals based on factors including but not limited to whether the individual is enrolled in an employer-sponsored group health benefit plan or an individual health benefit plan.

SECTION 27. ORS 735.728 is amended to read:

735.728. (1) Notwithstanding eligibility criteria and subsidy amounts established pursuant to ORS 735.720 to 735.740, subsidies shall be provided only to the extent the Legislative Assembly specifically appropriates funds to provide such assistance.

(2) The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall prohibit or limit enrollment in the Family Health Insurance Assistance Program to ensure that program expenditures are within legislatively appropriated amounts. Prohibitions or limitations allowed under this section may include but are not limited to:

(a) Lowering the allowable income level necessary to qualify as an eligible individual; and

(b) Establishing a waiting list of eligible individuals who shall receive subsidies only when sufficient funds are available.

SECTION 28. ORS 735.730 is amended to read:

735.730. The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** may, based on the recommendation of the Administrator of the Office for Oregon Health Policy and Research, establish minimum benefit requirements for individual health benefit plans subject to subsidy pursuant to the Family Health Insurance Assistance Program, including but not limited to the type of services covered and the amount of cost-sharing to be allowed.

SECTION 29. ORS 735.731 is amended to read:

735.731. (1) The Family Health Insurance Assistance Program shall provide coverage of age-appropriate immunizations or other health care services when an eligible individual is enrolled in a health benefit plan that does not provide coverage of age-appropriate immunizations or other health care services required by the state medical assistance program and the eligible individual is receiving a subsidy described in ORS 414.839.

(2) The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall adopt rules implementing subsection (1) of this section.

SECTION 30. ORS 735.732 is amended to read:

735.732. (1) Except as otherwise provided in this section **and ORS 735.710**, **the Office of Private Health Partnerships may not disclose** information provided to the [*Insurance Pool Governing Board*] **office** as part of an application for enrollment in the Family Health Insurance Assistance Program [*shall remain confidential*].

(2) The [*board*] **office** may exchange information provided to the [*board*] **office** with other state and federal agencies for the purposes of verifying eligibility for the program, improving provision of services and identifying economic trends relevant to administration of the program.

(3) In accordance with applicable state and federal law, the [*board*] **office** may require applicants to provide their Social Security numbers and use those numbers in the administration of the program.

SECTION 31. ORS 735.733 is amended to read:

735.733. The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall establish at least one basic benchmark health benefit plan that qualifies for a subsidy described by ORS 414.839. In establishing a basic benchmark plan, the [*board*] **office** shall consider employer-sponsored health benefit plans offered to employees and dependents of employees in Oregon.

SECTION 32. ORS 735.734 is amended to read:

735.734. The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships**, in consultation with the Administrator of the Office for Oregon Health Policy and Research **and the Department of Human Services**, shall adopt all rules necessary for the implementation and oper-

ation of the Family Health Insurance Assistance Program.

SECTION 33. ORS 735.736 is amended to read:

735.736. There is established in the State Treasury the Family Health Insurance Assistance Program Account, which shall consist of moneys appropriated to the account by the Legislative Assembly and interest earnings from the investment of moneys in the account. All moneys in the Family Health Insurance Assistance Program Account are continuously appropriated to the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** to carry out the provisions of ORS 735.720 to 735.740.

SECTION 34. ORS 735.740 is amended to read:

735.740. (1) The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** may impose sanctions against an individual who violates any provision of ORS 735.720 to 735.740 or rules adopted thereto, including but not limited to suspension or termination from the Family Health Insurance Assistance Program and repayment of any subsidy amounts paid due to the omission or misrepresentation of an applicant or enrolled individual. Sanctions allowed under this subsection shall be imposed in the manner prescribed in ORS chapter 183.

(2) In addition to the sanctions available pursuant to subsection (1) of this section, the [*board*] **office** may impose a civil penalty not to exceed $1,000 against any individual who violates any provision of ORS 735.720 to 735.740 or rules adopted pursuant thereto. Civil penalties imposed pursuant to this section shall be imposed pursuant to ORS 183.745.

SECTION 35. ORS 735.750 is amended to read:

735.750. As used in ORS 735.750 to 735.756:

(1) "Benefits plan" has the meaning given that term in ORS 735.605.

(2) "Other costs" means costs incurred by the Oregon Medical Insurance Pool that are not covered by the premiums received by the pool for a subsidized member.

(3) "Premium" has the meaning given that term in ORS 735.700.

(4) "Subsidized member" means a medical assistance program client who is enrolled in a benefits plan and who is receiving a subsidy from the Family Health Insurance Assistance Program [*of the Insurance Pool Governing Board*] established in ORS 735.720 to 735.740.

(5) "Subsidy" has the meaning given that term in ORS 735.720.

SECTION 36. ORS 735.754 is amended to read:

735.754. (1) In order to increase public subsidies for the purchase of health insurance coverage provided by public programs or private insurance described by ORS 414.839, the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships**, the Oregon Medical Insurance Pool Board and the Department of Human Services shall work cooperatively to obtain federal matching dollars. The [*Insurance Pool Governing Board*] **office**, the Oregon Medical Insurance Pool Board and the department shall develop a system for payment or reimbursement of other costs and subsidies provided to subsidized members.

(2) For each subsidized member, the Oregon Medical Insurance Pool Board shall determine:

(a) The full cost of administering the benefits plan of the subsidized member; and

(b) The amount of other costs.

(3) The Oregon Medical Insurance Pool Board shall bill the Family Health Insurance Assistance Program for the total amount of the premium received by the Oregon Medical Insurance Pool Board and for the amount of other costs. The program shall forward the bill to the department.

(4) The department shall pay the program an amount equal to the portion of the premium that is a subsidy and for other costs. The program shall forward the payment to the Oregon Medical

Insurance Pool Board.

SECTION 37. ORS 414.831 is amended to read:

414.831. The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall focus on expanding group coverage provided by the Family Health Insurance Assistance Program.

SECTION 38. ORS 743.730 is amended to read:

743.730. As used in ORS 743.730 to 743.773:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) "Eligible employee" means an employee of a small employer who works on a regularly

scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. "Eligible employee" includes sole proprietors, partners of a partnership, leased workers as defined in ORS 743.522 or independent contractors if they are included as employees under a health benefit plan of a small employer but does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the small employer for fewer than 90 days are not eligible employees unless the small employer so allows.

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

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

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

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

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

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

(A) Small employer group health benefit plans;

(B) Individual health benefit plans; or

(C) Portability health benefit plans.

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

(17) "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) "Health benefit plan" means any hospital expense, medical expense or hospital or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance policies, coverage of CHAMPUS services pursuant to contracts with the federal government, benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan, long term care insurance, hospital indemnity only, short term health insurance policies (the duration of which does not exceed six months including renewals), student accident and health insurance policies, dental only, vision only, a policy of stop-loss coverage that meets the requirements of ORS 742.065, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

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

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

(21) "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.

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

[*(23) "Insurance Pool Governing Board" means the Insurance Pool Governing Board established by ORS 735.704.*]

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

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg as amended and in effect on July 1, 1997;

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

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

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

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

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

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

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

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

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

(c) A preexisting conditions provision shall not be applied to a newborn child or adopted child who obtains coverage in accordance with ORS 743.707.

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

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

[*(30)*] **(29)** "Small employer" means any person, firm, corporation, partnership or association actively engaged in business that, on at least 50 percent of its working days during the preceding year, employed no more than 25 eligible employees and no fewer than two eligible employees, the majority of whom are employed within this state, and in which a bona fide partnership, independent contractor or employer-employee relationship exists. "Small employer" includes companies that are eligible to file a consolidated tax return pursuant to ORS 317.715.

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

SECTION 39. Section 5, chapter 742, Oregon Laws 2003, is amended to read:

Sec. 5. (1) The [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** shall submit to the Director of the Department of Consumer and Business Services any information requested by the director for the purpose of assessing the impact of the amendments to ORS 735.700, 735.702 and 735.710 by sections 1, 2 and 3**, chapter 742, Oregon Laws 2003** [*of this 2003 Act*].

(2) The [*board*] **office** shall report the results of the assessment conducted under subsection (1) of this section to the Seventy-fourth Legislative Assembly. The report shall include, but not be limited to:

(a) The demographics of small employers obtaining health benefit plans from the [*board*] **office**;

(b) The carriers with whom the [*board*] **office** has contracts to offer health benefit plans for small employers; and

(c) The premiums charged for health benefit plans for small employers.

SECTION 40. Section 2b, chapter 742, Oregon Laws 2003, is amended to read:

Sec. 2b. Health benefit plans for small employers offered by the [*Insurance Pool Governing Board*] **Office of Private Health Partnerships** under ORS 735.710 (8) that are not eligible for a subsidy under ORS 735.724 may be offered only to small employers that did not provide a health benefit plan for eligible employees on July 1, 2003, and to small employers that begin business operations on or after [*the effective date of this 2003 Act*] **September 2, 2003**.

SECTION 41. ORS 735.704 and 735.708 are repealed.

SECTION 42. ORS 735.700, 735.702, 735.706, 735.710 and 735.714 are added to and made a part of ORS 735.700 to 735.714.

SECTION 43. Sections 1, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12 of this 2005 Act, the amendments to ORS 414.831, 735.700, 735.702, 735.706, 735.710, 735.712, 735.714, 735.720, 735.722, 735.724, 735.726, 735.728, 735.730, 735.731, 735.732, 735.733, 735.734, 735.736, 735.740, 735.750, 735.754 and 743.730 and sections 2b and 5, chapter 742, Oregon Laws 2003, by sections 14, 16, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39 and 40 of this 2005 Act and the repeal of ORS 735.704 and 735.708 by section 41 of this 2005 Act become operative on January 1, 2006.

SECTION 44. This 2005 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2005 Act takes effect

on its passage.