CHAPTER 792

AN ACT SB 695

Relating to health care providers paid by the medical assistance program; amending ORS 192.493, 192.579, 414.025, 414.651, 414.736, 416.510, 741.300, 741.310, 743.061 and 743.847 and sections 14 and 64, chapter 602, Oregon Laws 2011; repealing ORS 414.727 and section 60, chapter 602, Oregon Laws 2011; and declaring an emergency.

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

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

Sec. 14. (1)**(a)** [*Notwithstanding ORS 414.631 and 414.651, in any area of the state where a coordinated care organization has not been certified,*] The Oregon Health Authority shall continue to contract with one or more prepaid managed care health services organizations, as defined in ORS [*414.736*] **414.025**, that [*serve the area and that*] are in compliance with contractual obligations owed to the state or local government **on the effective date of this 2015 Act and that serve:**

(A) A geographic area of the state that a coordinated care organization has not been certified to serve; or

(B) Individuals described in ORS 414.631 (2), (3) and (4).

(b) Contracts authorized by this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

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

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

[*(4) The authority shall continue to renew the contracts of prepaid managed care health services organizations that have a contract with the authority on July 1, 2011, until the earlier of the date the prepaid managed care health services organization becomes a coordinated care organization or July 1, 2014. Contracts with prepaid managed care health services organizations must terminate no later than July 1, 2017.*]

[*(5) The authority shall continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a coordinated care organization but no later than July 1, 2013.*]

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

SECTION 2. Section 64, chapter 602, Oregon Laws 2011, as amended by section 70, chapter 602, Oregon Laws 2011, and section 23, chapter 8, Oregon Laws 2012, is amended to read:

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

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

(3) ORS 414.610, [*414.630, 414.640,*] **414.615, 414.618,** 414.736, 414.738, 414.739 and 414.740 are repealed July 1, 2017.

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

SECTION 3. ORS 192.493 is amended to read:

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

(1) The amounts determined by an independent actuary retained by the agency to cover the costs of providing each of the following health services under ORS 414.631, 414.651 and 414.688 to 414.745 for the six months preceding the report:

(a) Inpatient hospital services;

(b) Outpatient hospital services;

(c) Laboratory and X-ray services;

(d) Physician and other licensed practitioner services;

(e) Prescription drugs;

(f) Dental services;

(g) Vision services;

(h) Mental health services;

(i) Chemical dependency services;

(j) Durable medical equipment and supplies; and

(k) Other health services provided under a coordinated care organization contract under ORS 414.651 or a contract with a prepaid managed care health services organization**, as defined in ORS 414.025**;

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

(3) Any adjustments made to the amounts reported under this section to account for geographic

or other differences in providing the health services; and

(4) The numbers of individuals served under each coordinated care organization contract or prepaid managed care health services organization contract, listed by category of individual.

SECTION 4. ORS 192.579 is amended to read:

192.579. (1) As used in this section, "entity" means a health care provider**, a coordinated care organization, as defined in ORS 414.025** or a prepaid managed care health services organization, as defined in ORS [*414.736*] **414.025**, that provides health care to an individual, if the care is paid for by a state health plan.

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

SECTION 5. 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 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) "Income" has the meaning given that term in ORS 411.704.

(9) "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) "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) "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) "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) "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) "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) "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) "Prepaid managed care health services organization" means a managed dental care, mental health or chemical dependency organization that contracts with the authority under section 14, chapter 602, Oregon Laws 2011, or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.

[*(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 6. ORS 414.651 is amended to read:

414.651. (1)(a) The Oregon Health Authority shall use, to the greatest extent possible, coordinated care organizations to provide fully integrated physical health services, chemical dependency and mental health services and oral health services. This section, and any contract entered into pursuant to this section, does not affect and may not alter the delivery of Medicaid-funded long term care services.

(b) The authority shall execute contracts with coordinated care organizations that meet the criteria adopted by the authority under ORS 414.625. Contracts under this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

(c) The authority shall establish financial reporting requirements for coordinated care organizations. The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each coordinated care organization and that:

(A) Enables the authority to verify that the coordinated care organization's reserves and other financial resources are adequate to ensure against the risk of insolvency; and

(B) Includes information on the three highest executive salary and benefit packages of each coordinated care organization.

(d) The authority shall hold coordinated care organizations, contractors and providers accountable for timely submission of outcome and quality data, including but not limited to data described in ORS 442.466, prescribed by the authority by rule.

(e) The authority shall require compliance with the provisions of paragraphs (c) and (d) of this subsection as a condition of entering into a contract with a coordinated care organization. A coordinated care organization, contractor or provider that fails to comply with paragraph (c) or (d) of this subsection may be subject to sanctions, including but not limited to civil penalties, barring any new enrollment in the coordinated care organization and termination of the contract.

(f)(A) The authority shall adopt rules and procedures to ensure that if a rural health clinic provides a health service to a member of a coordinated care organization, and the rural health clinic is not participating in the member's coordinated care organization, the rural health clinic receives total aggregate payments from the member's coordinated care organization, other payers on the claim and the authority that are no less than the amount the rural health clinic would receive in the authority's fee-for-service payment system. The authority shall issue a payment to the rural health clinic in accordance with this subsection within 45 days of receipt by the authority of a completed billing form.

(B) "Rural health clinic," as used in this paragraph, shall be defined by the authority by rule and

shall conform, as far as practicable or applicable in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

(2) The authority may contract with providers other than coordinated care organizations to provide integrated and coordinated health care in areas that are not served by a coordinated care organization or where the organization's provider network is inadequate. Contracts authorized by this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the authority for health services provided pursuant to ORS 414.631, 414.651 and 414.688 to 414.745 may not exceed the total dollars appropriated for health services under ORS 414.631, 414.651 and 414.688 to 414.745.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.631, 414.651 and 414.688 to 414.745 **and section 14, chapter 602, Oregon Laws 2011,** in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting to provide services under ORS 414.631, 414.651 and 414.688 to 414.745 shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) A coordinated care organization shall provide information to a member as prescribed by the authority by rule, including but not limited to written information, within 30 days of enrollment with the coordinated care organization about available providers.

(7) Each coordinated care organization shall work to provide assistance that is culturally and linguistically appropriate to the needs of the member to access appropriate services and participate in processes affecting the member's care and services.

(8) Each coordinated care organization shall provide upon the request of a member or prospective member annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to members.

(9) A coordinated care organization may not limit enrollment in a geographic area based on the zip code of a member or prospective member.

SECTION 7. ORS 414.736 is amended to read:

414.736. As used in [*ORS 192.493,*] this chapter[*, 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), (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) 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 8. ORS 416.510 is amended to read:

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

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

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

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

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

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

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

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

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

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

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

mental health organizations or chemical dependency organizations.] **has the meaning given that term in ORS 414.025.**

(11) "Recipient" means a recipient of assistance.

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

SECTION 9. 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.

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

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

[*(4)*] **(5)** "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)*] **(6)** "Health plan" means health insurance or health care coverage offered by an insurer.

[*(6)*] **(7)** "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 organization **or a coordinated care organization**.

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

[*(8)*] **(9)** "Prepaid managed care health services organization" has the meaning given that term in ORS [*414.736*] **414.025**.

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

SECTION 10. ORS 741.310 is amended to read:

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

(a) Beginning January 1, 2014:

(A) Individuals and families; and

(B) Employers with no more than 50 employees.

(b) Beginning October 1, 2015, districts and eligible employees of districts that are subject to ORS 243.886, unless their participation is precluded by federal law.

(c) Beginning January 1, 2016, employers with 51 to 100 employees.

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

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

(3) Only an insurer that has a certificate of authority to transact insurance in this state and that meets applicable federal requirements for participating in the exchange may offer a qualified health plan through the exchange. Any qualified health plan must be certified under subsection (4) of this section. Prepaid managed care health services organizations **and 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 shall adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans, including requirements that a qualified health plan provide, at a minimum, essential health benefits and have acceptable consumer and provider satisfaction ratings.

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

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

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

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

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

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

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

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

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

(11)(a) The corporation 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)(b) of this section and the insurers that may offer the plans.

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

(A) Any plan offered under subsection (1)(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)(b) of this section, the coverage is comparable to plans offered by the board.

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

SECTION 11. 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) The following individuals and groups may purchase qualified health plans through the health insurance exchange:

(a) Individuals and families;

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

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

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

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

(3) Only an insurer that has a certificate of authority to transact insurance in this state and that meets applicable federal requirements for participating in the exchange may offer a qualified health plan through the exchange. Any qualified health plan must be certified under subsection (4) of this section. Prepaid managed care health services organizations **and 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 shall adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans, including requirements that a qualified health plan provide, at a minimum, essential health benefits and have acceptable consumer and provider satisfaction ratings.

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

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

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

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

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

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

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

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

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

(11)(a) The corporation 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) of this section and the insurers that may offer the plans.

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

(A) Any plan offered under subsection (1)(c) 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) of this section, the coverage is comparable to plans offered by the board.

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

SECTION 12. ORS 743.061 is amended to read:

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

(a) Eligibility inquiry and response;

(b) Claim submission;

(c) Payment remittance advice;

(d) Claims payment or electronic funds transfer;
(e) Claims status inquiry and response;
(f) Claims attachments;
(g) Prior authorization;
(h) Provider credentialing; or
(i) Health care financial and administrative transactions identified by the stakeholder work group described in ORS 743.062.

(2) Any uniform standards adopted under subsection (1) of this section apply to:
(a) Health insurers.
(b) Prepaid managed care health services organizations as defined in ORS [*414.736*] **414.025**.
(c) Coordinated care organizations as defined in ORS 414.025.
[*(c)*] **(d)** Third party administrators.
[*(d)*] **(e)** Any person or public body that either individually or jointly establishes a self-insurance plan, program or contract, including but not limited to persons and public bodies that are otherwise exempt from the Insurance Code under ORS 731.036.
[*(e)*] **(f)** Health care clearinghouses or other entities that process or facilitate the processing of health care financial and administrative transactions from a nonstandard format to a standard format.
[*(f)*] **(g)** Any other person identified by the department that processes health care financial and administrative transactions between a health care provider and an entity described in this subsection.

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

SECTION 13. ORS 743.847 is amended to read:
743.847. (1) For the purposes of this section:
(a) "Health insurer" or "insurer" means an employee benefit plan, self-insured plan, managed care organization or group health plan, a third party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service.
(b) "Medicaid" means medical assistance provided under 42 U.S.C. 1396a (section 1902 of the Social Security Act).

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

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

(4) An insurer may not deny a claim submitted by the state Medicaid agency, a prepaid managed care health services organization**, as defined in ORS 414.025,** or a coordinated care organization**, as defined in ORS 414.025,** [*described in ORS 414.651*] under subsection (3) of this section based on the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point of sale that is the basis of the claim if:
(a) The claim is submitted by the agency, the prepaid managed care health services organization or the coordinated care organization within the three-year period beginning on the date on which the health care item or service was furnished; and
(b) Any action by the agency, the prepaid managed care health services organization or the coordinated care organization to enforce its rights with respect to the claim is commenced within six years of the agency's or organization's submission of the claim.

(5) An insurer must provide to the state Medicaid agency, a prepaid managed care health services organization or a coordinated care organization, upon request, the following information:
(a) The period during which a Medicaid recipient, the spouse or dependents may be or may have been covered by the plan;
(b) The nature of coverage that is or was provided by the plan; and
(c) The name, address and identifying numbers of the plan.

(6) An insurer may not deny enrollment of a child under the group or individual health plan of the child's parent on the ground that:
(a) The child was born out of wedlock;
(b) The child is not claimed as a dependent on the parent's federal tax return; or
(c) The child does not reside with the child's parent or in the insurer's service area.

(7) When a child has group or individual health coverage through an insurer of a noncustodial parent, the insurer must:
(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;
(b) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and
(c) Make payments on claims submitted in accordance with paragraph (b) of this subsection directly to the custodial parent, the provider or, if a claim is filed by the state Medicaid agency, a prepaid managed care health services organization or a coordinated care organization, directly to the agency or the organization.

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

coverage without regard to any enrollment season restrictions;

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

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

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

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

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

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

SECTION 14. ORS 414.727 and section 60, chapter 602, Oregon Laws 2011, are repealed.

SECTION 15. 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.

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