

Statutory Proposal for 2011 Session

THE OREGON BASE PLUS (OBP) HEALTH PLAN

Sponsored and Revised by Representative RICHARDSON

SUMMARY

- Establishes the "Oregon Base Plus" (OBP), health plan--a consumer focused, tax deductible health plan where eligible participants use funds from their own Health Savings Accounts or Health Opportunity Accounts to make point-of-service payments for health care with a health care debit card, while protecting the insured against catastrophic medical expenses with a high deductible health insurance policy.
- Deletes requirement for "Public Option" government administered health plan created by the 74th Oregon Legislative Session in House Bill 2009C.
- Requires low cost, high deductible health insurance policies with guaranteed issue and renewal for OBP plans to insure against catastrophic losses due to medical crisis.
- Allows taxpayer deduction from taxable income for costs of OBP plans, including policy costs and eligible HSA contributions.
- Establishes portability for OBP plans, paid for by employers, when employment ends.
- Specifies maximum deductible, coinsurance and out-of-pocket expenses.
- Exempts OBP plans from compulsory benefits not required by federal law.
- Requires OBP plans to offer Health Savings Account or Health Opportunity Account options for payment of copayments and routine health related expenses.
- Requires OBP plans to issue a standardized Oregon Health Card, a health care debit card, for point-of-service payment for routine health services.
- Requires OBP plans to provide web-based access to participants regarding their HSA and HOA balances.
- Redefines the Oregon Health Insurance Exchange to provide information and assistance to eligible individuals and employers regarding consumer-based health insurance products described in this Act.
- Establishes web-based access to provide information and comparisons regarding available plans, assistance in choosing plans and information and forms relating to end-of-life documents.

A BILL FOR AN ACT--Relating to health insurance and its tax deductibility.

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

SECTION 1. Definitions. As used in sections 1 to 16 of this 2011 Act, the term:

(1) "Applicant" means an individual seeking to participate in the Oregon Health Insurance Exchange.

(2) “Carrier” means any person or organization subject to the authority of the Director of the Department of Consumer and Business Services or Oregon Health Authority that provides health benefit plans or insurance in this state and includes an insurer, a health care service contractor, a fraternal benefit society, a health maintenance organization and a multiple employer welfare arrangement.

(3) “Dependent” means:

- (a) The spouse of the principal insured; or**
- (b) An individual who is related to the principal insured by birth, marriage or adoption and who also meets the definition of a dependent as set forth in the United States Internal Revenue Code (26 U.S.C. 152).**

(4) “Eligible individual” means an individual who is eligible to participate in the Oregon Health Insurance Exchange by reason of meeting one or more of the following qualifications:

(a) The individual is an Oregon resident, meaning that the individual is and continues to be legally domiciled and physically residing on a permanent and full-time basis in a place of permanent habitation in Oregon that remains the person’s principal residence and from which the person is absent only for temporary or transitory purposes. A person who is a full-time student attending an institution outside Oregon may maintain his or her Oregon residency.

(b) The individual is not an Oregon resident but is employed, at least 20 hours a week on a regular basis, at an Oregon location by a bona fide employer, and the individual’s employer does not offer a group health insurance plan, or the individual is not eligible to participate in any group health insurance plan offered by the individual’s employer.

(c) The individual, whether a resident or not, is enrolled in, or eligible to enroll in, a participating employer plan.

(d) The individual is self-employed in Oregon and, if a nonresident self-employed individual, the individual’s principal place of business is in Oregon.

(e) The individual is a full-time student attending an institution of higher education located in Oregon.

(f) The individual, whether a resident or not, is a dependent of

another individual who is an eligible individual.

(5) “Employer” means any individual, partnership, association, corporation, business trust or person or group of persons employing one or more individuals and filing payroll tax information on such individual or individuals.

(6) “Excepted benefits” means Medicare supplement insurance, specified disease insurance, dental only or vision only insurance, accident only insurance, hospital confinement indemnity coverage, coverage issued as a supplement to liability insurance, long-term care insurance, workers’ compensation insurance, loss of income insurance, coverage for medical expenses included as part of any auto, property, casualty or other liability insurance and credit or disability insurance.

(7) “Exchange” means the Oregon Health Insurance Exchange created in section 17 of the 74th Oregon Legislature’s House Bill 2009C.

(8) “Participating individual” means an individual who has been determined by the Oregon Health Insurance Exchange to be, and continues to remain, an eligible individual for purposes of obtaining coverage under participating insurance plans offered through the Oregon Health Insurance Exchange.

(9) “Participating insurance plan” means a health benefit plan, as defined in ORS 743.730, that is offered through the Oregon Health Insurance Exchange.

(10) “Plan year” means the 12-month period of time during which the insured is covered under a health benefit plan, as stipulated in the contract governing the plan.

(11) “Preexisting condition provision” means a provision in a health benefit plan that limits, denies or excludes benefits for a period of time for an enrollee for expenses or services related to a medical condition that was present before the date the coverage commenced, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. The time period for a preexisting conditions provision begins when an application for insurance is made or when an applicant is in a waiting period for coverage under any plan. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

(12) “Rate” means the premiums or fees charged by a health benefit plan for coverage under the plan.

SECTION 2. Oregon Health Insurance Exchange.

(1) The Oregon Health Insurance Exchange is to henceforth provide the residents of Oregon, and such other individuals as may be eligible to participate via the internet and otherwise with the following:

- (a) information regarding the benefits to individuals of access to health insurance products utilizing flexible, tax deductible, consumer controlled Health Savings and Health Opportunity Accounts, in conjunction with high deductible health insurance policies;**
- (b) comparisons of benefits and features of competing policies and related services provided by participating insurers;**
- (c) information and comparisons relating to costs of medical procedures and services, their outcomes, efficacy, etc.**
- (d) information on portability of participating plans regardless of whether or not premiums have been paid or subsidized by an Oregon employer.**
- (e) Coordinate with the Oregon Health Authority and Department of Consumer and Business Services the implementation and oversight of the provisions of this 2011 Act.**

(2) [Language shall be drafted to accomplish the following.] The provisions of House Bill 2009C of the 74th Oregon Legislative session, which are now incorporated in the Oregon Revised Statutes, shall be amended to enable the Oregon Health Insurance Exchange to operate in accordance with sections 1 to 16 of this 2011 Act.

(3) All eligible individuals shall be permitted to obtain health insurance benefits through the Oregon Health Insurance Exchange as provided in sections 1 to 16 of this 2011 Act.

SECTION 3. Limitations of Exchange.

The Oregon Health Insurance Exchange shall not create, offer or operate a “public option,” government administered health plan, but shall promote among Oregon residents the benefits of Health Savings Accounts, Health Opportunity Accounts, high deductible health insurance policies and other policy related provisions of this Act, and the importance of having health insurance in general.

SECTION 4. Portability.

Participating plans subsidized or paid in full by an employer shall be portable and shall remain in force as non-cancellable, guaranteed renewable individual health policies after the termination of employment, so long as the premiums are paid in a timely manner, whether by the insured or otherwise.

SECTION 5. Duties of exchange. The Oregon Health Insurance Exchange shall:

(1) Publicize the existence of the exchange and disseminate information on eligibility requirements and enrollment procedures for the exchange.

(2) Promote ease of enrolling eligible individuals in the exchange.

(3) Establish and administer an Insurance Policy Access Center website where individuals can examine available health insurance options. The website shall be designed to assist an individual in making comparisons and determining the cost of available health insurance options and in determining which health insurance options best suit the individual's needs.

(4) Establish and administer procedures for the election of coverage by participating individuals, including preparing and distributing to participating individuals:

(a) Descriptions of the coverage, benefits, limitations, copayments and premiums for all participating plans; and

(b) Forms and instructions for electing coverage and arranging payment for coverage.

(c) The Oregon Health Card, which shall utilize electronic point-of-service payments.

(5) To the extent advisable to enable federal tax deductibility for employers, to comply with federal requirements for Medicaid, Medicare or other federal money match regulations or otherwise, and after coordinating with participating insurers, collect and transmit to the applicable participating plans premium payments or contributions made by or on behalf of participating individuals, including developing mechanisms to:

(a) Receive and process automatic payroll deductions for participating individuals enrolled in participating employer plans;

(b) Enable participating individuals to pay, in whole or part, for coverage through the exchange by electing to assign to the exchange any federal earned income tax credit payments due the participating individual; and

(c) Receive and process any federal or state tax credits or other premium support payments for health insurance that may be established by law.

(6) Upon request, issue certificates of previous coverage to all such individuals who cease to be covered by a participating insurance plan.

(7) To the extent advisable after coordinating with private health insurers, establish procedures to account for all funds received and disbursed by the exchange, including:

(a) Maintaining a separate, segregated management account for the receipt and disbursement of moneys allocated to fund the administration of the exchange; and

(b) Maintaining a separate, segregated operations account for the receipt of all premium payments or contributions made by or on behalf of participating individuals and the distribution of premium payments to participating plans.

(8) Submit by electronic means to the Department of Consumer and Business Services, the Oregon Health Authority, and members of the Oregon Assembly following the end of each plan year, the report of an independent audit of the exchange's accounts for the plan year and relevant information relating thereto.

(9) Develop and provide incentives for eligible individuals to complete end-of-life documents, such as advance directives, Physician Orders for Life Sustaining Treatment (POLST), etc., as part of the enrollment process.

SECTION 6. Powers of the Exchange.

The Oregon Health Insurance Exchange may:

(1) Contract with vendors to perform one or more of the functions specified in section 5 of this 2011 Act.

(2) Contract with private or public social service agencies to administer application, eligibility verification, enrollment and premium payments for

specified groups or populations of eligible individuals or participating individuals.

(3) Act as the plan administrator, when required by federal law for eligibility to receive federal money-match dollars, for participating employer plans under contract with the employers and to undertake the obligations required of a plan administrator by federal law.

(4) Set and collect fees from participating individuals, participating employers and participating insurance plans sufficient to fund the cost of administering the exchange.

(5) Seek and directly receive grant funding from the United States government, departments or agencies of this state, county or municipal governments or private philanthropic organizations to defray the costs of operating the exchange.

(6) Establish and administer rules and procedures governing the operations of the exchange.

(7) Establish one or more service centers within this state to facilitate enrollment that will be accessible by internet, telephone and, if deemed necessary, in person.

(8) Sue and be sued or otherwise take any necessary or proper legal action.

(9) To the extent advisable after coordinating with private health insurers, administer or coordinate administration of the provisions of this 2011 Act relating to Oregon Health Card, Health Savings Accounts, and Health Opportunity Accounts.

SECTION 7. Participation.

(1) Any eligible individual may apply for an OBP health plan described in this 2011 Act, and any Oregon resident may access information and assistance related to OBP policies with the Oregon Health Insurance Exchange. An employer, a labor union or an educational, professional, civic, trade, church or social organization that has eligible individuals as employees or members may apply on behalf of those individuals. If the exchange determines that an individual is eligible to participate in the exchange, the individual may enroll, or be enrolled by the individual's parent or legal guardian, in a participating insurance plan offered through the exchange.

(2) An eligible individual may not be denied coverage for an OBP policy at a time for any of the following reasons, provided the individual applies for coverage within 63 days of the triggering event:

(a) The individual loses coverage in an existing health insurance plan due to the death of a spouse, parent or legal guardian;

(b) The individual or a covered dependent loses coverage in an existing health insurance plan due to a change in the individual's employment status;

(c) The individual or a covered dependent loses coverage in an existing health insurance plan because of a divorce, separation or other change in familial status;

(d) The individual loses coverage in an existing health insurance plan because the individual achieves an age at which coverage lapses under that plan;

(e) The individual or a covered dependent becomes eligible by becoming a resident of Oregon or because the individual's place of employment has been changed to Oregon;

(f) The individual becomes eligible by becoming the spouse or dependent, by reason of marriage, birth, adoption, court order or a change in custody arrangement, of an eligible individual;

(g) The individual becomes subject to a court order requiring the individual to provide health insurance coverage to dependents or enters into a new arrangement for the custody of dependents that requires the individual to provide health insurance for those dependents; or

(h) The individual loses coverage in a plan offered through the exchange by reason of the plan's terminating participation in the exchange before the end of the plan year.

SECTION 8. Plans offered through exchange.

(1) A health insurance plan may not be offered through the Oregon Health insurance Exchange unless the Director of the Department of Consumer and Business Services or the Oregon Health Authority has first certified to the exchange that:

(a) The carrier seeking to offer the plan is authorized to issue health insurance in this state and is in good standing; and

- (b) The plan meets the requirements of this section, and the plan and the carrier are in compliance with all other applicable health insurance laws of this state.**
- (2) The director may not certify a plan that excludes an eligible individual from coverage.**
- (3) Each certification of a plan is valid for a term of at least one year, but may be automatically renewable from term to term in the absence of notice that:**

 - (a) The carrier is no longer authorized to issue health insurance in this state; or**
 - (b) The plan or the carrier is no longer a participant in the exchange.**
- (4) The director may withdraw certification of a plan only after notice to the carrier and opportunity for hearing, except that the director may decline to renew the certification of any carrier at the end of a certification term without opportunity for hearing.**
- (5) Each certified plan offered through the exchange shall contain a detailed description of benefits offered, including maximums, limitations, exclusions and other benefit limits.**
- (6) Each certified plan offered through the exchange shall provide, subject to the plan's deductibles and coinsurance or copayment schedule, major medical coverage that includes the following:**

 - (a) Hospital benefits;**
 - (b) Surgical benefits;**
 - (c) In-hospital medical benefits;**
 - (d) Ambulatory patient benefits;**
 - (e) Prescription drug benefits;**
 - (f) Mental health benefits; and**
 - (g) Incentives for healthful living, preventative care, chronic disease care.**
- (7) Carriers shall offer plans through the exchange at rates that are based on age, geography, healthful and harmful lifestyle habits, family**

composition and such other criteria that are determined to be actuarially sound and reasonable by the director.

(8) The rates determined for the first plan year for which each plan is offered through the exchange may be adjusted by the carrier for subsequent plan years based on experience and any later modifications to plan benefits, provided that any adjustments in rates are made in advance of the plan year for which the adjustment will apply and are approved by the director.

(9) The exchange shall not decline or refuse to offer, or otherwise restrict the offering to any participating individual of, any plan that has obtained, in a timely fashion in advance of the annual open enrollment period, certification by the director in accordance with the provisions of this section.

(10) The exchange shall not sponsor or endorse for individual health insurance any government insurance or benefit or contract with any carrier to offer any state sponsored insurance or benefit plan for individual health insurance.

(11) Notwithstanding any existing Oregon law mandating inclusion of coverage for health benefits to the contrary, excepting for health benefits required by federal law, the exchange shall not impose on or require to be included in any participating plan, or on any carrier or plan seeking to participate in the exchange, any terms or conditions with respect to rates or health benefits.

(12) The director shall establish and administer regulations and procedures for certifying plans to participate in the exchange in accordance with the provisions of this section.

SECTION 9. Deductibles; coinsurance.

(1) Participating insurance plans may include deductibles in amounts not to exceed an annual deductible of \$5,000 per participant.

(2) After an amount of eligible expenses equal to the OBP plan's annual deductible has been paid by the insured, from the insured's HSA or otherwise, a participating plan may include a copayment requirement not to exceed 20 percent of the cost of the next \$5,000 in benefits covered under the plan. In any calendar year, the maximum out-of-pocket cost may not exceed \$1,000 for an individual, or \$3,000 for the insured and all qualified dependents in a OBP individual health care plan.

(3) A participating plan shall provide a thirty-day minimum carry-over provision. An insured may carry over to a subsequent calendar year eligible expenses incurred in at least the final 30 days of any calendar year in which the deductible was not been met.

(4) All participating insurance plans must provide a maximum lifetime benefit of at least \$1 million.

SECTION 10. Health Savings Accounts and Health Opportunity Accounts.

(1) Each participating insurance plan shall offer a Health Savings Account (HSA), to be funded at the discretion of the insured in by annual contributions not to exceed the deductible selected by the applicant, as set forth in Section 9 of this 2011 Act. All such HSA contributions for the insured may be used to reduce the insured's taxable income under ORS chapter 316, as set forth in Section 17 of this Act.

(2) Funds in the Health Savings Account may be used for bona fide health-related expenses such as medical, chiropractic, naturopathic, dental, vision, pre-natal and childbirth expenses, and addiction treatment performed by a licensed practitioner, and bona fide ambulance expenses and prescription drugs. The insurer may limit costs to be applied toward the deductible to those benefits covered under the insurance plan.

(3) Funds in the Health Savings Account that exceed the amount of the OBP plan deductible multiplied by the number of insured participants in the plan (insured and all covered dependents), may be used for the benefit of the insured or the insured's immediate family members, which shall include the insured's parents, spouse and children, to pay the following: long-term care insurance premiums, long-term care expenses for elderly or disabled individuals that are paid to licensed care givers and/or licensed care facilities, qualified job training and other educational expenses.

(4) Health Opportunity Accounts (HOA) are subsidized accounts similar to Health Savings Accounts for Medicaid eligible, low income residents. The HSA provisions of this subsection's paragraph (2) shall also apply to HOA's. The Exchange shall present to the Oregon Health Authority a recommended design for an Oregon HOA demonstration program, and upon approval by the legislature, a federal waiver shall be sought for Oregon pursuant to the federal Health Opportunity Accounts Demonstration Program.

[Several states have adopted HOA demonstration programs and much can be learned from their experience before designing an HOA demonstration program for Oregon. For additional information on

Health Opportunity Accounts, go to:

<http://www.cms.hhs.gov/smdl/downloads/HOAp reprintfinal112906.pdf>]

(5) Subsidization by the state of OBP policy premiums and/or Health Opportunity Accounts, with or without federal matching funds, shall be means tested for those participants with household incomes greater than 135% of the federal poverty level.

(6) Participating plans that are subsidized may be required by the state to be administered by a licensed health maintenance organization.

(7) Income earned by the state from investment of HSA and HOA funds shall accrue to the state to offset OBP costs and for other state purposes.

(8) At the termination of the insured's involvement in a participating plan,

(a) the HSA balance, if any, may be transferred to a successor HSA within 90 days of the date of termination from the participating plan; or

(b) the HSA balance, if any and upon the written election of the insured, shall be subject to the roll over provisions applicable to Individual Retirement Accounts, and may be transferred to an IRA or other retirement account qualified to receive IRA roll over contributions where eligible under federal tax law; or

(c) the HSA balance, if any and upon the written election of the insured, shall be made payable to the insured, subject to a 20% withholding provision;

(d) the HOA balance, if any, shall revert to the state of Oregon.

SECTION 11. Oregon Health Card.

(1) A participating insurance plan shall provide a standardized Oregon Health Card (OHC) to each insured. The card shall be used to pay for health care services at the point and time of services. The insurer shall offer 24-hour Internet access or toll-free telephone verification, or both, for each insured to obtain HSA or HOA account balances and identification of services previously paid from the account.

(2) The Oregon Health Card shall utilize electronic benefits transfer technology. Health Savings Account or Health Opportunity Account contributions shall be credited to the cardholder's OHC.

(3) A participating insurer shall offer 24-hour Internet access or toll-free telephone verification, or both, to health providers to verify coverage and

to charge against the Oregon Health Card account in the event the provider does not have electronic benefits transfer technology.

(4) Any unused portion of the Health Savings Account or Health Opportunity Account carries over to the following plan year.

(5) Internet access and telephone verification shall require User-Name and Password for each insured, or other credible procedure to ensure information is provided only when access has been granted by the insured.

SECTION 12. Preexisting conditions.

(1) Eighty-percent (80%) of a participating insurance plan's payments for care or treatment for conditions existing within six months prior to the date of application shall be reimbursed to a participating insurance plan by the Oregon Medical Insurance Pool under ORS 735.600 to 735.650.

(2) The Oregon Medical Insurance Pool's reimbursement payments shall terminate for expenses incurred after six consecutive months in which the insured does not receive necessary care or treatment for the condition subject to subsection (1) of this section.

SECTION 13. Guaranteed renewal.

(1) A participating insurance plan may not cancel or refuse to renew an eligible individual's policy, subject to the carrier's rules regarding cancellation for nonpayment of premiums or fraud. A participating insurance plan may not cancel or refuse to renew a policy because of any change in employer or employment status, marital status, health status, age, membership in any organization or other change that does not affect eligibility.

(2) An insured eligible individual who is not a resident of this state and who experiences a qualifying event may continue coverage for a period not to exceed 36 months from the date of the qualifying event if the qualifying event is:

(a) Loss of eligible individual status because of voluntary or involuntary termination of employment for reasons other than gross misconduct; or

(b) Loss of qualified dependent status for any reason.

(3) A person electing to continue coverage under subsection (2) of this section must notify the Oregon Health Insurance Exchange of the election within 63 days after the qualifying event.

SECTION 14. Dispute resolution.

(1) The Director of the Department of Consumer and Business Services or the Oregon Health Authority shall establish procedures for resolving disputes arising from the operation of the Oregon Health Insurance Exchange, including disputes relating to:

(a) The eligibility of an individual to participate in the exchange;

(b) The imposition of a coverage surcharge on a participating individual by a participating insurance plan; and

(c) The imposition of a preexisting condition provision on a participating individual by a participating plan.

(2) If a carrier imposes a preexisting condition provision exclusion or a premium surcharge in connection with enrollment of a participating individual in a participating insurance plan offered by the carrier, and the participating individual disputes the imposition of such an exclusion or surcharge, the participating individual may request that the director issue a determination as to the validity or extent of the exclusion or surcharge. The director shall issue a determination within 30 days after the request is filed with the department.

SECTION 15. Participating employer plans.

(1) Any employer may apply to the Oregon Health Insurance Exchange to be the tax qualified sponsor of a participating employer plan. If desired by the applying employer or if required by federal law for tax deductibility by the employer, an employer seeking to be the sponsor of a participating employer plan shall, as a condition of participation in the exchange, enter into a binding agreement with the exchange, which shall include the following conditions:

(a) The sponsoring employer designates the exchange director to be the plan administrator for the employer's group health plan, and the exchange director agrees to undertake the obligations required of a plan administrator under federal law.

(b) The coverage and benefits offered by participating insurance plans shall constitute the coverage and benefits of the participating employer plan.

(2) Any individuals eligible to participate in the exchange by reason of their eligibility for coverage under the participating employer plan, regardless of

whether any such individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan, may elect coverage under any insurance plan participating in the exchange, and neither the employer nor the exchange shall limit such individual's choice of coverage from among all the participating insurance plans.

SECTION 16. Exclusivity.

(1) An insurer may issue or renew an individual health insurance plan other than through the Oregon Health Insurance Exchange, but tax deductibility provisions under the terms of Section 17 of this 2011 Act shall apply only to participating plans.

(2) As set forth in Section 10 of this 2011 Act, participating plans which are subsidized and contain Health Opportunity Accounts may be required by the state to be administered through a licensed health maintenance organization (HMO).

SECTION 17. Tax deduction.

Every eligible individual who purchases a participating insurance plan shall be entitled to use the costs of the plan, including the premium for health insurance and eligible contributions to the health savings account, to reduce taxable income under ORS chapter 316.

SECTION 18. Advance directives.

The Insurance Policy Access Center website established in section 5 of this 2011 Act shall provide information and assistance in completing advance directives, living wills or other end-of-life documents.

SECTION 19. The Oregon Health Insurance Exchange Account.

The Oregon Health Insurance Exchange Account is established separate and distinct from the General Fund. All moneys received by the Oregon Health Insurance Exchange, other than appropriations from the General Fund, shall be deposited to the account and are continuously appropriated to the exchange to carry out the duties, functions and powers of the exchange.

SECTION 20. Section Captions.

The section captions used in this 2011 Act are provided only for the convenience of the reader and do not become part of the statutory law of

this state or express any legislative intent in the enactment of this 2011 Act.