

# Senate Bill 770

Sponsored by Senators MANNING JR, DEMBROW, BEYER, Representatives FAHEY, KENY-GUYER, SALINAS, WILLIAMSON; Senators BURDICK, FAGAN, FREDERICK, GOLDEN, PROZANSKI, RILEY, TAYLOR, WAGNER, Representatives ALONSO LEON, BYNUM, DOHERTY, GOMBERG, GORSEK, HELM, HERNANDEZ, HOLVEY, MARSH, MCLAIN, MEEK, MITCHELL, NERON, NOSSE, PILUSO, POWER, PRUSAK, RAYFIELD, REARDON, SANCHEZ, SCHOUTEN, SMITH WARNER, WILDE, WITT

## SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced**.

Establishes Health Care for All Oregon Board to be responsible for planning and oversight of Health Care for All Oregon Plan to be administered by Oregon Health Authority. Provides comprehensive health care coverage to all individuals residing or working in Oregon. Repeals health insurance exchange upon implementation of Health Care for All Oregon Plan.

Supplants coverage by private insurers for health services covered by plan. Authorizes Public Employees' Benefit Board and Oregon Educators Benefit Board to offer supplemental health benefit plans to employees. Requires public employees to be covered by Health Care for All Oregon Plan.

Establishes Health Care for All Oregon Fund. Continuously appropriates moneys in fund to Health Care for All Oregon Board.

Establishes office of Health Care for All Oregon Ombudsman in office of Governor.

Requires Health Care for All Oregon Board to establish Regional Planning Boards to oversee allocation of health resources in geographic regions prescribed by Health Care for All Oregon Board. Requires submission to Regional Planning Board of plans for addition, alteration or construction of health care facility except long term care facility. Authorizes Health Care for All Oregon Board to provide public funding upon request if addition, alteration or construction approved. Transfers to Department of Human Services authority to approve certificate of need for long term care facility.

Appropriates moneys from General Fund to Health Care for All Oregon Board for purposes of Health Care for All Oregon Plan.

Declares emergency, effective on passage.

## A BILL FOR AN ACT

Relating to statewide health care coverage; creating new provisions; amending ORS 238.538, 243.105, 243.107, 243.125, 243.129, 243.135, 243.140, 243.160, 243.163, 243.185, 243.215, 243.221, 243.275, 243.285, 243.860, 243.864, 243.866, 243.867, 243.868, 243.874, 243.886, 292.051, 346.565, 352.237, 408.370, 408.380, 411.400, 411.402, 411.406, 413.011, 413.017, 413.032, 413.037, 414.025, 414.115, 430.021, 430.315, 431.120, 441.025, 441.060, 441.065, 441.550, 441.710, 442.015, 442.315, 442.362, 442.394, 442.396, 471.752, 479.210, 677.450, 731.036, 742.400, 743A.001, 743A.012, 743A.063, 743A.067, 743A.070, 743A.080, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.141, 743A.148, 743A.160, 743A.168, 743A.170, 743A.175, 743A.188, 743A.190, 743A.192, 743A.252, 743B.005, 743B.010, 743B.020, 743B.128, 743B.505 and 750.055 and section 2, chapter 771, Oregon Laws 2013; repealing ORS 243.142, 243.144, 243.877, 413.085, 442.325, 442.342, 442.344, 442.347, 735.601, 735.604, 735.608, 735.611, 735.617, 741.001, 741.002, 741.003, 741.004, 741.008, 741.102, 741.105, 741.220, 741.222, 741.300, 741.310, 741.340, 741.342, 741.381, 741.390, 741.400, 741.500, 741.510, 741.520, 741.540, 741.800, 741.801, 741.802, 741.900, 743.826 and 743B.130 and section 36a, chapter 3, Oregon Laws 2015; and declaring an emergency.

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

## ESTABLISHMENT OF THE HEALTH CARE FOR ALL OREGON PLAN

**NOTE:** Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

**SECTION 1. (1) The Health Care for All Oregon Plan is established to:**

**(a) Ensure access to comprehensive, quality, patient-centered, equitable and affordable publicly funded health care for all individuals living or working in Oregon;**

**(b) Improve the public's health; and**

**(c) Control the cost of health care for the benefit of individuals, families, businesses and society.**

**(2) An individual is eligible to participate in the plan if the individual:**

**(a) Resides in Oregon;**

**(b) Is employed in Oregon full-time and pays any personal income tax dedicated to the plan;**

**(c) Is a dependent, as defined by rule by the Health Care for All Oregon Board, of an individual described in paragraph (a) or (b) of this subsection; or**

**(d) Meets other criteria established by the board.**

**SECTION 2. (1) The Health Care for All Oregon Board shall design the delivery and financing of health care funded by the Health Care for All Oregon Plan in order to:**

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

**(b) Ensure transparency and accountability.**

**(c) Enhance primary care.**

**(d) Allow the choice of health care provider.**

**(e) Respect the primacy of the patient-provider relationship.**

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

**(g) Reduce administrative costs.**

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

**(i) Ensure adequate compensation of health care providers.**

**(j) Incorporate community-based systems.**

**(k) Include effective cost controls.**

**(L) Provide universal access to care even if the participant is outside of this state.**

**(m) Provide seamless birth-to-death access to care.**

**(n) Minimize medical errors.**

**(o) Focus on preventive health care.**

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

**(q) Include long term care.**

**(r) Provide equitable access to health care, according to a participant's needs.**

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

**(2) The board shall administer the plan according to all of the following principles:**

**(a) Health care, as a human right, must be accessible to everyone without exception.**

**(b) Health care resources and services must be distributed and accessed according to people's needs. Health, income, employment, age, race, gender, immigration status and other factors should not create any barriers to health care or disparities in health outcomes.**

**(c) The health care system must be accountable to the people it serves. It must ensure effective delivery of care and stewardship of resources that improve individual and overall population health and provide the means to maintain human rights standards in the distribution and delivery of health care.**

**(d) The health care system must be open to the public with regard to information, decision-making and management.**

1 (e) The health care system must enable meaningful public participation in all decisions  
2 affecting people's right to health care.

3 (f) Health care, as a fundamental element of a just society, must not be rationed by cost  
4 as a commodity in private markets, but must be secured to the people on an equitable basis  
5 by public means, similar to public education, public safety and public utilities.

6 (3) The plan shall pay the costs of health services that are medically necessary or med-  
7 ically appropriate for the maintenance of health, the prevention of health problems and the  
8 diagnosis, treatment or rehabilitation of health conditions, within the scope of coverage  
9 prescribed by the board, including but not limited to the following categories of health ser-  
10 vices:

11 (a) Primary and preventive care, including health education;

12 (b) Specialty care;

13 (c) Inpatient and outpatient hospital care and emergency care;

14 (d) Home health care;

15 (e) Prescription drugs according to a drug formulary;

16 (f) Durable medical equipment, including prosthetics;

17 (g) Mental and behavioral health services;

18 (h) Substance abuse treatment;

19 (i) Dental services;

20 (j) Chiropractic and naturopathic services;

21 (k) Women's health services;

22 (L) Ophthalmic services, as well as basic vision and vision correction;

23 (m) Diagnostic imaging, laboratory services and other diagnostic and evaluation services;

24 (n) Inpatient and outpatient rehabilitative services, including physical, speech and occu-  
25 pational therapy;

26 (o) Emergency transportation;

27 (p) Translation of spoken and written language;

28 (q) Palliative and hospice care;

29 (r) Podiatry;

30 (s) Acupuncture;

31 (t) Dialysis; and

32 (u) Telemedicine, as it becomes available and effective.

33 (4) The board shall determine the details for the plan's coverage of health services, in-  
34 cluding schedules for preventive, diagnostic and health maintenance services and pre-  
35 scription drugs, in accordance with the following criteria:

36 (a) The plan must cover all services required by Medicare, Medicaid or the Patient Pro-  
37 tection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education  
38 Reconciliation Act (P.L. 111-152), and by any other federal program that provides funds for  
39 the plan.

40 (b) The plan must cover all services that were covered by the health benefit plans offered  
41 by the Oregon Educators Benefit Board and the Public Employees' Benefit Board on the ef-  
42 fective date of this 2019 Act, unless there is strong medical evidence that coverage of specific  
43 services should be discontinued.

44 (c) The board shall consider:

45 (A) The short-term clinical effectiveness and cost-effectiveness of a service, based upon

1 multiple sources of evidence;

2 (B) Safety;

3 (C) In addition to symptoms and the immediate causes of symptoms, the underlying fac-  
4 tors that result in the need for care; and

5 (D) The importance of a patient's comfort with, and acceptance of, a service as clinically  
6 valuable.

7 (d) The plan must cover health services that:

8 (A) Are evidence-based and cost-effective in promoting health; and

9 (B) Emphasize disease prevention and health promotion.

10 (e) Subject to the requirements to provide comprehensive care and all medically neces-  
11 sary and medically appropriate care, the board may set limits on the reimbursement paid for  
12 medical equipment and devices in order to encourage the use of the most economical equip-  
13 ment and devices. If the board limits the reimbursement paid for medical equipment and  
14 devices, the board shall have a procedure that allows a plan participant to apply the re-  
15 imbursement amount toward the cost of a more costly type of equipment or device if, in the  
16 discretion of the participant's health care provider, the equipment or device is medically  
17 necessary or medically appropriate for the participant's health needs.

18 (f) Health care services that are cosmetic may be covered if necessary for the participant  
19 to obtain employment, to improve mental health or to function in society.

20 (5) Copayments, deductibles or other forms of cost-sharing may not be imposed on par-  
21 ticipants under the plan.

22 (6) Participants in the plan may choose any health care provider licensed, certified or  
23 registered in this state or in another state for services within the scope of the provider's  
24 license, certification or registration.

25 (7) Within the scope of services covered within each category, participants and their  
26 health care providers shall determine whether a treatment is medically necessary or med-  
27 ically appropriate.

28 (8) The plan and any health care provider reimbursed by the plan may not discriminate  
29 against any participant on the basis of race, religion, sex, sexual orientation, gender identity,  
30 national origin, age, income or any basis prohibited by the civil rights laws of this state.

31 (9) The plan may not discriminate against any health care provider who is licensed, cer-  
32 tified or registered in this state and who is acting within the provider's scope of practice.

33 (10) A health care provider reimbursed by the plan may not be required to offer any  
34 particular service unless denial of the service amounts to discrimination against a partic-  
35 ipant or class of participants.

36 (11) Except as provided in subsection (4)(e) of this section, a health care provider shall  
37 accept payment from the plan for services covered by the plan as payment in full and may  
38 not bill a patient for an amount exceeding the reimbursement amount under the plan.

39 (12)(a) Administrative costs of the plan may not exceed:

40 (A) Twelve percent of the total costs of the plan during the first two years of plan op-  
41 eration.

42 (B) Eight percent of the total costs of the plan during the third and fourth years of plan  
43 operation.

44 (C) Five percent of the total costs of the plan during the fifth and subsequent years of  
45 plan operation.

1 (b) During the first four years of plan operation, total costs include transition costs and  
 2 the costs of retraining provided to workers displaced by the plan, as described in section 10  
 3 of this 2019 Act.

4 (13) A participant's loss of eligibility due to no longer meeting the criteria specified in  
 5 section 1 of this 2019 Act is a qualifying event for the purpose of continuation coverage re-  
 6 quired by 29 U.S.C. 1161. The Oregon Health Authority shall be considered to be a plan  
 7 sponsor of a group health plan and shall notify the participant losing coverage and the de-  
 8 pendents of the participant losing coverage of the option to continue coverage at the  
 9 participant's own expense.

10 **SECTION 3.** No later than October 1, 2023, the Health Care for All Oregon Board estab-  
 11 lished under section 7 of this 2019 Act shall develop and submit to the Legislative Assembly  
 12 a recommendation for the coverage of long term care services by the Health Care for All  
 13 Oregon Plan.

14 **SECTION 4.** Sections 5 and 6 of this 2019 Act are added to and made a part of the In-  
 15 surance Code.

16 **SECTION 5.** Notwithstanding any other provision of law, an insurer with a certificate of  
 17 authority to transact insurance in this state may not offer in this state a policy or certificate  
 18 of health insurance that reimburses the costs of health services covered under the Health  
 19 Care for All Oregon Plan.

20 **SECTION 6.** Actions taken by insurers may not be considered to be the transaction of  
 21 insurance for purposes of the Insurance Code if the actions are:

- 22 (1) Taken in accordance with the requirements adopted pursuant to sections 2, 9 and 11  
 23 of this 2019 Act; and
- 24 (2) Approved by the Oregon Health Authority or the Health Care for All Oregon Board.

25  
 26 **HEALTH CARE FOR ALL OREGON BOARD**  
 27

28 **SECTION 7.** (1) There is established the Health Care for All Oregon Board, consisting of  
 29 nine members appointed by the Governor and subject to confirmation by the Senate in the  
 30 manner prescribed by ORS 171.562 and 171.565. The membership must represent every con-  
 31 gressional district in this state and include:

- 32 (a) Two licensed health care providers, one of whom is not a physician licensed under  
 33 ORS chapter 677;
- 34 (b) Two persons with significant education and experience in public health;
- 35 (c) Two persons with extensive demonstrated experience in health care consumer advo-  
 36 cacy;
- 37 (d) One representative of organized labor;
- 38 (e) One representative of business; and
- 39 (f) One public member.

40 (2)(a) During the tenure of a member of the board and the period immediately preceding  
 41 the member's appointment to the board, the member may not have a direct or indirect fi-  
 42 nancial or pecuniary interest or investment in, or be employed by, a pharmaceutical com-  
 43 pany, health insurer or medical supply company.

44 (b) This subsection does not prohibit a person from having a financial interest resulting  
 45 from investments made by a pension fund or through mutual funds, blind trusts or similar

1 investments where the person does not exercise control over the nature, amount or timing  
2 of the investment.

3 (c) A board member shall sign an agreement that the member will not be employed by,  
4 or have voting or decision-making power for, a pharmaceutical company, health insurer or  
5 medical supply company for a period of five years after tenure as a board member ceases.

6 (3) The term of office of each member is four years and begins on the January 2 next  
7 following appointment. A new term begins on the expiration of the previous term. A member  
8 is eligible for reappointment for a new term. The Governor shall appoint a person to fill any  
9 vacancy, subject to confirmation by the Senate. Any appointment to a vacant position shall  
10 become immediately effective for the unexpired term.

11 (4) The board shall select one of its members as chairperson and another as vice chair-  
12 person, for such terms and with duties and powers necessary for the performance of the  
13 functions of such offices as the board determines.

14 (5) A majority of the members of the board constitutes a quorum for the transaction of  
15 business.

16 (6) The board shall meet at a place, day and hour determined by the chairperson or a  
17 majority of the members of the board.

18 (7) Consistent with ORS chapter 244, the board shall adopt rules of ethics and definitions  
19 of conflicts of interest for determining the circumstances under which members of the board  
20 must recuse themselves from voting.

21 (8) A member of the board is entitled to compensation and expenses as provided in ORS  
22 292.495 for participation in board, committee and subcommittee meetings.

23 (9)(a) The board may establish such advisory and technical committees as the board  
24 considers necessary. The committees may be continuing or temporary. The board shall de-  
25 termine the representation, membership, terms and organization of the committees and shall  
26 appoint their members.

27 (b) Members of advisory and technical committees, other than board members, are not  
28 entitled to compensation, but in the discretion of the board may be reimbursed from funds  
29 available to the board for actual and necessary travel and other expenses incurred by them  
30 in the performance of their official duties in the manner and amount provided in ORS 292.495.

31 (10) In accordance with applicable provisions of ORS chapter 183, the board may adopt  
32 rules necessary for the administration of the laws that the board is charged with adminis-  
33 tering.

34 (11) The Oregon Health Authority shall provide staff support for the board and its com-  
35 mittees and subcommittees until the board hires an executive director under section 9 of this  
36 2019 Act. The executive director and the executive director's subordinates shall provide staff  
37 support once the executive director and subordinates are in place.

38 **SECTION 8.** Notwithstanding section 7 of this 2019 Act:

39 (1) The members first appointed to the Health Care for All Oregon Board shall be ap-  
40 pointed as soon as practicable after the effective date of this 2019 Act and:

41 (a) Two shall serve for terms ending December 31, 2021.

42 (b) Three shall serve for terms ending December 31, 2022.

43 (c) Four shall serve for full terms.

44 (2) The two members described in subsection (1)(a) of this section and the three members  
45 described in subsection (1)(b) of this section shall be determined by a random drawing.

1           **(3) During the two-year period beginning upon the appointment of all of the members of**  
2 **the board, the board shall meet every business day until the Governor dissolves the Transi-**  
3 **tion Commission pursuant to section 23 of this 2019 Act.**

4           **SECTION 9. (1) The Health Care for All Oregon Board is the policy-making body respon-**  
5 **sible for planning and oversight of the development, implementation and management of the**  
6 **Health Care for All Oregon Plan, including but not limited to all of the following:**

7           **(a) Seeking all waivers, exemptions and agreements from federal, state and local gov-**  
8 **ernment sources that are necessary to provide funding for the plan, including funding from**  
9 **Medicare for the participation of Medicare recipients in the plan.**

10           **(b) Determining and regularly updating the scope of coverage within each category de-**  
11 **scribed in section 2 (3) of this 2019 Act in consultation with plan participants and guided by**  
12 **evidence-based practices that integrate clinical expertise, patient values and current re-**  
13 **search.**

14           **(c) Determining the package of benefits covered in the plan in accordance with section**  
15 **2 of this 2019 Act.**

16           **(d) Managing the Health Care for All Oregon Fund established under section 13 of this**  
17 **2019 Act.**

18           **(e) Determining policies and adopting rules to guide the operation of the plan, including**  
19 **but not limited to:**

20           **(A) Establishing eligibility standards for participation, including standards for**  
21 **presumptive eligibility determinations;**

22           **(B) Developing quality of care indicators;**

23           **(C) Ensuring meaningful access by plan participants to quality health services;**

24           **(D) Establishing policies regarding conflicts of interest for health care providers and**  
25 **health care facilities providing health services to plan participants;**

26           **(E) Regularly soliciting input from the public, including individuals with special health**  
27 **care needs, through regional advisory committees appointed under section 17 of this 2019 Act**  
28 **and other means; and**

29           **(F) Ensuring that the plan is implemented in accordance with section 2 of this 2019 Act.**

30           **(f) Hiring an executive director who serves at the pleasure of the board and who, subject**  
31 **to approval by the board, shall appoint all subordinate officers and employees that the exec-**  
32 **utive director deems necessary and shall prescribe their duties and fix their compensation.**

33           **(g) Approving contracts for items and services provided by health care providers to plan**  
34 **participants.**

35           **(h) Partnering with public health agencies to take steps to improve the health of the**  
36 **overall population.**

37           **(i) Reporting, at least annually, to the Legislative Assembly during a regular session on**  
38 **the performance of the plan, and recommending needed legislative changes.**

39           **(j) Submitting to the Legislative Assembly recommendations for adjusting tax rates as**  
40 **necessary for taxes imposed to finance the plan.**

41           **(k) Ensuring that an annual financial audit of the revenues and expenses of the plan is**  
42 **conducted.**

43           **(L) Establishing policies and procedures to ensure that health care providers receive fair,**  
44 **adequate and timely reimbursement for services covered by the plan and that the plan pro-**  
45 **motes the effective and efficient delivery of health services.**

1 (m)(A) Establishing policies, and determining the allocation of resources through the  
2 regional planning process under sections 16 and 17 of this 2019 Act, to promote regional eq-  
3 uity in access to health care facilities and to prevent unnecessary duplication of medical  
4 equipment and facilities.

5 (B) Requiring a health care provider organization or health care facility that has a gross  
6 revenue exceeding an amount determined by the board to adopt separate budgets for its  
7 capital expenditures and operational expenditures in order to:

8 (i) Promote transparency about costs and the sources of costs;

9 (ii) Facilitate regional planning for the statewide distribution of capital resources that is  
10 effective and cost-efficient for participants in the region; and

11 (iii) Support public accountability and public participation in planning for the distribution  
12 of health care facilities and resources.

13 (n) Establishing and implementing procedures to ensure that plan participants are bona  
14 fide residents of this state or are employed full-time in this state, or are dependents of such  
15 residents or employees.

16 (2) The board and the board's advisory committees shall:

17 (a) Investigate alternative methods for reimbursing health care providers, including  
18 global budgets, capitation payments and fee-for-service payments, to determine the appro-  
19 priate method for reimbursing providers in a manner that best promotes the policies and  
20 principles described in section 2 of this 2019 Act;

21 (b) Investigate the feasibility of making the plan the single conduit for processing all  
22 claims for health care reimbursement in this state;

23 (c) Use data from the Oregon Health Authority's all-claims, all-payer database, described  
24 in ORS 413.032, to assess clinical effectiveness and safety, and investigate ways to make re-  
25 porting information to the database less burdensome on health care providers; and

26 (d) Seek federal approval as necessary to reform the use of federal funds in financing  
27 health care in this state, in order to emphasize efficiency, transparency and accountability  
28 without risking substantial federal health care funding.

29 (3) The board is authorized to purchase stop-loss coverage to pay for catastrophic costs  
30 incurred by the plan.

31 (4)(a) The board may establish criteria under which an individual residing or working in  
32 this state may be exempt from participating in the Health Care for All Oregon Plan if the  
33 individual:

34 (A) Is enrolled in a health benefit plan offered to federal employees or is enrolled in an-  
35 other out-of-state plan; and

36 (B) Would be adversely affected by enrolling in the Health Care for All Oregon Plan.

37 (b) For individuals who are exempt under this subsection, the board may allow payments  
38 from the Health Care for All Oregon Fund to:

39 (A) Supplement the reimbursement paid to the individual's health care provider by the  
40 individual's health benefit plan, up to the amount of reimbursement allowed by the Health  
41 Care for All Oregon Plan; or

42 (B) Provide to the individual an amount to reimburse the individual's copayment or other  
43 cost-sharing under the individual's health benefit plan.

44 (5) The board may delegate any of the duties described in this section to the Oregon  
45 Health Authority subject to any conditions imposed by the board.



1       **SECTION 10.** (1) The Health Care for All Oregon Board, in consultation with the Transi-  
 2       tion Commission established under section 23 of this 2019 Act, shall establish a program to  
 3       be operated for a four-year period beginning on the operative date specified in section 115  
 4       of this 2019 Act, to pay or reimburse the costs of retraining for workers displaced by the  
 5       implementation of the Health Care for All Oregon Plan. The Oregon Health Authority shall  
 6       administer the program.

7             (2) Each worker is eligible for up to 24 months of retraining under this section.

8             (3) The board shall apply for any federal and private gifts and grants that may be avail-  
 9       able to operate the program. If federal and private gifts and grants are insufficient to meet  
 10       the cost of the program, the board may use moneys deposited in the Health Care for All  
 11       Oregon Fund for the purposes of this section.

12  
 13                               **DUTIES OF OREGON HEALTH AUTHORITY IN**  
 14                               **ADMINISTERING THE HEALTH CARE FOR ALL OREGON PLAN**

15  
 16       **SECTION 11.** The Oregon Health Authority, under the direction, policies and oversight  
 17       of the Health Care for All Oregon Board, shall:

18             (1) Adopt rules necessary for carrying out this section and sections 1, 2, 9 and 16 of this  
 19       2019 Act;

20             (2) Direct ongoing, effective communication and outreach to ensure that Oregonians are  
 21       well informed about the Health Care for All Oregon Plan;

22             (3) Process applications and determine eligibility for individuals seeking to participate or  
 23       to renew participation in the plan;

24             (4) Propose goals, objectives and standards to achieve quality and affordable health care  
 25       accessible to all Oregonians, and propose major policy changes to the board;

26             (5) Establish systems to monitor and evaluate the access to, and the quality and cost of,  
 27       health services provided to Oregonians;

28             (6) Make recommendations to the board for ensuring equity in the delivery of culturally  
 29       appropriate health services to all Oregonians;

30             (7) Assist the board in negotiations with the federal government, with local governments  
 31       and with other state agencies as necessary to implement the plan;

32             (8) Direct research to improve health and health services;

33             (9) Identify legislation needed to improve the health services covered under the plan;

34             (10) Establish collaborative partnerships with other public health agencies;

35             (11) Develop a biennial budget to recommend to the board;

36             (12) Administer the legislatively approved budget for the plan;

37             (13) Report periodically to the board, the Governor and the Legislative Assembly on the  
 38       progress of implementing the plan and on the financial status of the plan;

39             (14) Arrange for appropriate and timely support that allows the board to carry out the  
 40       board's functions;

41             (15) Ensure prompt payment for all plan expenditures;

42             (16) Subject to the board's approval, enter into contracts with entities to process health  
 43       care claims and payments;

44             (17) Contract for actuarial, legal, technical or other professional services as needed;

45             (18) Enter into contracts with health care providers to provide health services on favor-

1 able terms and prices;

2 (19) Establish a system for monitoring the health services covered by the plan to ensure  
 3 that the health services are medically necessary or medically appropriate, and take remedial  
 4 actions as necessary to correct the underutilization, overutilization or inappropriate delivery  
 5 of health services; and

6 (20) Perform any other functions delegated to the authority by the board.  
 7

8 **HEALTH CARE FOR ALL OREGON OMBUDSMAN**  
 9

10 **SECTION 12.** (1) The office of the Health Care for All Oregon Ombudsman is established  
 11 in the office of the Governor.

12 (2) The Governor shall appoint a Health Care for All Oregon Ombudsman, who shall serve  
 13 at the pleasure of the Governor for a term of four years. The ombudsman may be reap-  
 14 pointed for additional terms.

15 (3) The ombudsman may appoint a deputy ombudsman and any other subordinate officers  
 16 and employees necessary for the performance of the duties of the ombudsman and shall  
 17 prescribe their duties and fix their compensation.

18 (4) The ombudsman shall adopt contested case procedures, in accordance with ORS  
 19 chapter 183, for a health care provider or a participant in the Health Care for All Oregon  
 20 Plan to file a complaint to contest any adverse actions by the Health Care for All Oregon  
 21 Board, the Oregon Health Authority, or any person contracting with the board or the au-  
 22 thority, with respect to eligibility for, services and coverage under and payments made in the  
 23 plan.

24 (5) The ombudsman shall address complaints from health care providers, participants and  
 25 contractors. In the investigation of any complaint, the ombudsman may subpoena any person  
 26 to give sworn testimony or to produce documents or other evidence that is reasonably ma-  
 27 terial to the investigation.

28 (6) By September 1 of each even-numbered year, the ombudsman shall submit to the  
 29 Oregon Department of Administrative Services a funding request for the next biennium. The  
 30 funding request shall be prepared in accordance with generally accepted accounting princi-  
 31 ples. If the department approves the request, the department shall direct the Health Care  
 32 for All Oregon Board to transfer the moneys from the Health Care for All Oregon Fund to  
 33 the department to be made available to the ombudsman for the operating expenses and ad-  
 34 ministration of the office of the Health Care for All Oregon Ombudsman.  
 35

36 **HEALTH CARE FOR ALL OREGON FUND**  
 37

38 **SECTION 13.** (1) The Health Care for All Oregon Fund is established in the State Treas-  
 39 ury, separate and distinct from the General Fund. The Health Care For All Oregon Fund  
 40 shall consist of moneys received under sections 10, 14 and 25 of this 2019 Act, moneys ap-  
 41 propriated by the Legislative Assembly and moneys received from federal, state, county and  
 42 local governments and private sources to pay for health services covered by the Health Care  
 43 for All Oregon Plan. Moneys in the Health Care for All Oregon Fund are continuously ap-  
 44 propriated to the Health Care for All Oregon Board to administer the Health Care for All  
 45 Oregon Plan and to carry out the provisions of this section and sections 1, 2, 7, 9 to 12, 14,

1 16 and 17 of this 2019 Act. Notwithstanding ORS 293.190, moneys in the Health Care for All  
 2 Oregon Fund do not revert to the General Fund.

3 (2) The board shall transfer from the Health Care for All Oregon Fund to the office of  
 4 the Health Care for All Oregon Ombudsman established under section 12 of this 2019 Act, the  
 5 amount approved by the Oregon Department of Administrative Services under section 12 (6)  
 6 of this 2019 Act for the operating expenses and administration of the office.

7 **SECTION 14.** (1) The Health Care for All Oregon Plan shall be the primary payer of re-  
 8 imbursement for health services covered by the plan, including but not limited to  
 9 compensable medical services covered by workers' compensation insurance under ORS  
 10 656.245.

11 (2) The Oregon Health Authority is subrogated to the rights of any plan participant who  
 12 has a claim against an insurer, tortfeasor, employer, third party administrator, pension  
 13 manager, public or private corporation, government entity or any other person that may be  
 14 liable for the cost of health services provided to the plan participant and paid for by the plan.

15 (3) The authority may enter into an agreement with any person for the prepayment of  
 16 claims anticipated to arise under subsection (2) of this section during a biennium. At the end  
 17 of each biennium, the authority shall appropriately charge or refund to the payer the dif-  
 18 ference between the amount prepaid and the amount due.

19 (4) All moneys recovered pursuant to this section shall be deposited in the Health Care  
 20 for All Oregon Fund established under section 13 of this 2019 Act and may be used for any  
 21 purposes specified for the fund.

22  
 23 **FINANCING OF THE HEALTH CARE FOR ALL OREGON PLAN**  
 24

25 **SECTION 15.** (1) The Health Care for All Oregon Board shall develop recommendations  
 26 for dedicated funding mechanisms to finance the Health Care for All Oregon Plan. The rec-  
 27 ommendations shall be based on the results of the study conducted under section 1, chapter  
 28 712, Oregon Laws 2013. In lieu of premiums, copayments, coinsurance, deductibles or other  
 29 forms of cost-sharing, the plan must be financed by a system of dedicated, progressive taxes  
 30 that are based on the payer's ability to pay.

31 (2) Funding sources must be assessed based on the capacity of the source to generate  
 32 sufficient revenue to finance the plan. The burden of the assessments must be distributed  
 33 according to ability to pay.

34 (3) The board shall report its recommendations to the appropriate interim committees  
 35 of the Legislative Assembly in the manner provided by ORS 192.245 no later than September  
 36 30, 2020.

37  
 38 **REGIONAL HEALTH PLANNING**  
 39

40 **SECTION 16.** (1) As used in this section, "health care facility" has the meaning given that  
 41 term in ORS 442.015, excluding long term care facilities.

42 (2) The Health Care for All Oregon Board shall divide this state into geographic regions,  
 43 each encompassing an area of a size that will facilitate the planning, allocation and coordi-  
 44 nation of health services for the residents in the region. There must be at least one region  
 45 for each congressional district.

1       **(3) For each region, the board shall establish a Regional Planning Board consisting of**  
2 **seven members who reside in the region and include:**

3       **(a) At least two individuals with extensive health care consumer advocacy experience;**

4       **(b) Individuals with significant expertise in public health and planning and in the delivery**  
5 **of health care; and**

6       **(c) Individuals selected from among nominees recommended in response to an extensive**  
7 **solicitation to a broad range of health care providers and health care consumer advocacy**  
8 **organizations.**

9       **(4) The purposes of the Regional Planning Boards are to:**

10       **(a) Ensure that the distribution of health resources, including health care facilities, ma-**  
11 **chines, devices and services, is equitable throughout this state in order to achieve optimal**  
12 **population health; and**

13       **(b) Promote accountability, transparency and public participation in the expenditure of**  
14 **public and private funds in the health care industry.**

15       **(5) Before an entity purchases equipment, expands a health care facility or constructs a**  
16 **new health care facility, the cost of which exceeds a threshold established by the Health Care**  
17 **for All Oregon Board, the entity shall submit the proposal to the Regional Planning Board**  
18 **for the area where the equipment or facility is located. The Oregon Health Authority may**  
19 **prescribe the form and manner for the submission of the proposal. The proposal must include**  
20 **an estimate of any projected changes in operating costs resulting from the purchase or**  
21 **construction and other information requested by the Regional Planning Board.**

22       **(6) Each Regional Planning Board shall, following widespread public notice, conduct a**  
23 **public hearing to solicit input from the members of the community regarding each proposal**  
24 **submitted under subsection (5) of this section. The Regional Planning Board shall compile**  
25 **the input into a report, submit the report to the proposer and to the Health Care for All**  
26 **Oregon Board and make the report readily available to the public. If the entity is requesting**  
27 **public funding for the proposal, the Regional Planning Board shall submit recommendations**  
28 **to the Health Care for All Oregon Board, which shall decide whether to approve the request**  
29 **and the amount of funding to be provided.**

30       **(7) All meetings of the Regional Planning Boards are subject to ORS 192.610 to 192.690.**

31       **(8) In identifying regional needs for services, equipment and health care facilities, a Re-**  
32 **gional Planning Board shall hold public hearings and solicit advice from:**

33       **(a) Regional advisory committees described in section 17 of this 2019 Act;**

34       **(b) Coordinated care organizations with members residing in the region;**

35       **(c) Health care provider groups and professional and trade organizations;**

36       **(d) Patient and health care consumer advocacy organizations; and**

37       **(e) Other organizations and groups operating in the region as necessary to obtain advice**  
38 **that is representative of the interests of residents in the region.**

39       **(9) The Oregon Health Authority shall provide staff support to the Regional Planning**  
40 **Boards and to each regional advisory committee.**

41       **SECTION 17. The Health Care for All Oregon Board shall appoint a regional advisory**  
42 **committee for each region described in section 16 of this 2019 Act. Each committee shall**  
43 **consist of residents of the region who will advise the Health Care for All Oregon Board and**  
44 **the Regional Planning Board for the region. The regional advisory committees shall:**

45       **(1) Solicit input from the public;**

1       **(2) Receive and investigate complaints from residents of the region about health care**  
 2 **providers or services and forward complaints, as the committee deems appropriate, to the**  
 3 **Health Care for All Oregon Ombudsman;**

4       **(3) Conduct public hearings; and**

5       **(4) Assist the Health Care for All Oregon Board and the Regional Planning Boards as**  
 6 **necessary to ensure that the health service needs of the region's residents can be met.**

7       **SECTION 18.** ORS 431.120 is amended to read:

8       431.120. In addition to the duties described in ORS 431.115, the Oregon Health Authority shall:

9       (1) Enforce the laws, rules and policies of this state related to health.

10       (2) Routinely conduct epidemiological investigations for each case of sudden infant death syn-  
 11 drome, including the identification of risk factors such as birth weight, maternal age, prenatal care,  
 12 history of apnea and socioeconomic characteristics. The authority may conduct the investigations  
 13 through local health departments only upon adoption by rule of a uniform epidemiological data col-  
 14 lection method.

15       (3) Adopt rules related to loans and grants awarded under ORS 285B.560 to 285B.599 or 541.700  
 16 to 541.855 for the improvement of drinking water systems for the purpose of maintaining compliance  
 17 with applicable state and federal drinking water quality standards. In adopting rules under this  
 18 subsection, the authority shall coordinate the authority's rulemaking process with the Water Re-  
 19 sources Department and the Oregon Business Development Department to ensure that rules adopted  
 20 under this subsection are consistent with rules adopted under ORS 285B.563 and 541.845.

21       *[(4) Control health care capital expenditures by administering the state certificate of need program*  
 22 *under ORS 442.325 to 442.344.]*

23       **SECTION 19.** ORS 441.025, as amended by section 12, chapter 50, Oregon Laws 2018, is  
 24 amended to read:

25       441.025. (1)(a) Upon receipt of a license fee and an application to operate a health care facility  
 26 other than a long term care facility, the Oregon Health Authority shall review the application and  
 27 conduct an on-site inspection of the health care facility. The authority shall issue a license if it finds  
 28 that the applicant and health care facility comply with ORS 441.015 to 441.087 and 441.196 and the  
 29 rules of the authority provided that the authority does not receive within the time specified a cer-  
 30 tificate of noncompliance issued by the State Fire Marshal, deputy, or approved authority pursuant  
 31 to ORS 479.215.

32       (b) The authority shall, following payment of the fee, annually renew each license issued under  
 33 this subsection unless:

34       (A) The health care facility's license has been suspended or revoked; or

35       (B) The State Fire Marshal, a deputy or an approved authority has issued a certificate of non-  
 36 compliance pursuant to ORS 479.215.

37       (2)(a) Upon receipt of a license fee and an application to operate a long term care facility, the  
 38 Department of Human Services shall review the application and conduct an on-site inspection of the  
 39 long term care facility. The department shall issue a license if the department finds that the appli-  
 40 cant and long term care facility comply with ORS 441.015 to 441.087 and 441.196 and the rules of  
 41 the department provided that it does not receive within the time specified a certificate of noncom-  
 42 pliance issued by the State Fire Marshal, deputy, or approved authority pursuant to ORS 479.215.

43       (b) The department shall, following an on-site inspection and payment of the fee, annually renew  
 44 each license issued under this subsection unless:

45       (A) The long term care facility's license has been suspended or revoked;

1 (B) The long term care facility is found not to be in substantial compliance following the on-site  
2 inspection; or

3 (C) The State Fire Marshal, a deputy or an approved authority has issued a certificate of non-  
4 compliance pursuant to ORS 479.215.

5 (3) Each license shall be issued only for the premises and persons or governmental units named  
6 in the application and shall not be transferable or assignable.

7 (4) Licenses shall be posted in a conspicuous place on the licensed premises as prescribed by  
8 rule of the authority or the department.

9 (5) [No] A license [shall] **may not** be issued or renewed for any health care facility or health  
10 maintenance organization that [*is required to obtain a certificate of need under ORS 442.315 until a*  
11 *certificate of need has been granted. An ambulatory surgical center is not subject to the certificate of*  
12 *need requirements in ORS 442.315*] **fails to comply with the requirements of section 16 of this**  
13 **2019 Act.**

14 (6) [No] A license [shall] **may not** be issued or renewed for any skilled nursing facility or  
15 intermediate care facility, unless the applicant has included in the application the name and such  
16 other information as may be necessary to establish the identity and financial interests of any person  
17 who has incidents of ownership in the facility representing an interest of 10 percent or more thereof.  
18 If the person having such interest is a corporation, the name of any stockholder holding stock rep-  
19 representing an interest in the facility of 10 percent or more shall also be included in the application.  
20 If the person having such interest is any other entity, the name of any member thereof having in-  
21 cidents of ownership representing an interest of 10 percent or more in the facility shall also be in-  
22 cluded in the application.

23 (7) A license may be denied to any applicant for a license or renewal thereof or any stockholder  
24 of any such applicant who has incidents of ownership in the health care facility representing an  
25 interest of 10 percent or more thereof, or an interest of 10 percent or more of a lease agreement for  
26 the facility, if during the five years prior to the application the applicant or any stockholder of the  
27 applicant had an interest of 10 percent or more in the facility or of a lease for the facility and has  
28 divested that interest after receiving from the authority or the department written notice that the  
29 authority or the department intends to suspend or revoke the license or to decertify the facility from  
30 eligibility to receive payments for services provided under this section.

31 (8) The Department of Human Services may not issue or renew a license for a long term care  
32 facility, unless the applicant has included in the application the identity of any person who has in-  
33 cident of ownership in the long term care facility who also has a financial interest in any pharmacy,  
34 as defined in ORS 689.005.

35 (9) The authority shall adopt rules for each type of health care facility, except long term care  
36 facilities, to carry out the purposes of ORS 441.015 to 441.087 including, but not limited to:

37 (a) Establishing classifications and descriptions for the different types of health care facilities  
38 that are licensed under ORS 441.015 to 441.087; and

39 (b) Standards for patient care and safety, adequate professional staff organizations, training of  
40 staff for whom no other state regulation exists, suitable delineation of professional privileges and  
41 adequate staff analyses of clinical records.

42 (10) The department shall adopt rules for each type of long term care facility to carry out the  
43 purposes of ORS 441.015 to 441.087 including, but not limited to:

44 (a) Establishing classifications and descriptions for the different types of long term care facili-  
45 ties that are licensed under ORS 441.015 to 441.087; and

1 (b) Standards for patient care and safety, adequate professional staff organizations, training of  
 2 staff for whom no other state regulation exists, suitable delineation of professional privileges and  
 3 adequate staff analyses of clinical records.

4 (11) The authority or department may not adopt a rule requiring a health care facility to serve  
 5 a specific food as long as the necessary nutritional food elements are present in the food that is  
 6 served.

7 (12) A health care facility licensed by the authority or department may not:

8 (a) Offer or provide services beyond the scope of the license classification assigned by the au-  
 9 thority or department; or

10 (b) Assume a descriptive title or represent itself under a descriptive title other than the classi-  
 11 fication assigned by the authority or department.

12 (13) A health care facility must reapply for licensure to change the classification assigned or the  
 13 type of license issued by the authority or department.

14 **SECTION 20.** ORS 441.060 is amended to read:

15 441.060. (1) The Oregon Health Authority shall make or cause to be made on-site inspections of  
 16 health care facilities licensed under ORS 441.025 (1) at least once every three years.

17 **(2) Any license or prospective applicant desiring to make specified types of alterations**  
 18 **or additions to its health care facilities or to construct new health care facilities shall, before**  
 19 **commencing such alteration, addition or new construction, comply with section 16 of this**  
 20 **2019 Act.**

21 [(2)] **(3)** [*The authority and*] The Department of Human Services may prescribe by rule that any  
 22 licensee or prospective applicant desiring to make specified types of alteration or addition to its  
 23 **long term care or residential care** facilities or to construct new facilities shall, before commenc-  
 24 ing such alteration, addition or new construction, either prior to or after receiving a certificate of  
 25 need pursuant to ORS 442.315, if required, submit plans and specifications therefor to the [*authority*  
 26 *or the*] department for preliminary inspection and approval or recommendations with respect to  
 27 compliance with the rules authorized by ORS 441.025 and 443.420 and for compliance with National  
 28 Fire Protection Association standards when [*the*] a facility is also to be Medicare or Medicaid cer-  
 29 tified.

30 [(3)] **(4)** The authority or the department may require by rule payment of a fee for project review  
 31 services at a variable rate, dependent on total project cost.

32 [(4)] **(5)** For health care facilities, the authority shall develop a review fee schedule as minimally  
 33 necessary to support the staffing level and expenses required to administer the program.

34 [(5)] **(6)** For long term care facilities and residential care facilities, the department shall develop  
 35 a review fee schedule as minimally necessary to support the staffing level and expenses required to  
 36 administer the program. The fee for project review of residential care facilities shall equal two-  
 37 thirds that required of health care facilities.

38 [(6)] **(7)** The authority or the department may also conduct an on-site review of projects as a  
 39 prerequisite to licensure of new facilities, major renovations and expansions. The authority and the  
 40 department shall, at least annually, with the advice of the facilities covered by the review, present  
 41 proposed rule changes regarding facility design and construction to such agencies for their consid-  
 42 eration.

43 [(7)] **(8)** The authority shall publish a state submissions guide for health care facility projects  
 44 and advise project sponsors of applicable requirements of federal, state and local regulatory agen-  
 45 cies.

1        [(8)] (9) The department shall publish a state submissions guide for long term care facility and  
 2 residential care facility projects and advise project sponsors of applicable requirements of federal,  
 3 state and local regulatory agencies.

4        **SECTION 21.** ORS 442.315, as amended by section 23, chapter 608, Oregon Laws 2013, and  
 5 section 10, chapter 718, Oregon Laws 2017, is amended to read:

6        442.315. (1) Any [*new hospital or*] new skilled nursing or intermediate care service or facility  
 7 [*not excluded pursuant to*] **other than a facility described in** ORS 441.065 shall obtain a certificate  
 8 of need from the [*Oregon Health Authority*] **Department of Human Services** prior to an offering  
 9 or development.

10        (2) The [*authority*] **department** shall adopt rules specifying criteria and procedures for making  
 11 decisions as to the need for the new services or facilities.

12        (3)(a) An applicant for a certificate of need shall apply to the [*authority*] **department** on forms  
 13 provided for this purpose by [*authority rule*] **the department**.

14        (b) An applicant shall pay a fee prescribed as provided in this section. Subject to the approval  
 15 of the Oregon Department of Administrative Services, the [*authority*] **Department of Human Ser-**  
 16 **vices** shall prescribe application fees, based on the complexity and scope of the proposed project.

17        (4) The [*authority*] **Department of Human Services** shall be the decision-making authority for  
 18 the purpose of certificates of need. The [*authority*] **department** may establish an expedited review  
 19 process for an application for a certificate of need to rebuild a long term care facility, relocate  
 20 buildings that are part of a long term care facility or relocate long term care facility bed capacity  
 21 from one long term care facility to another. The [*authority*] **department** shall issue a proposed order  
 22 not later than 120 days after the date a complete application for expedited review is received by the  
 23 [*authority*] **department**.

24        (5)(a) An applicant or any affected person who is dissatisfied with the proposed decision of the  
 25 [*authority*] **department** is entitled to an informal hearing in the course of review and before a final  
 26 decision is rendered.

27        (b) Following a final decision being rendered by the [*authority*] **department**, an applicant or any  
 28 affected person may request a reconsideration hearing pursuant to ORS chapter 183.

29        (c) In any proceeding brought by an affected person or an applicant challenging [*an authority*]  
 30 **a department** decision under this subsection, the [*authority*] **department** shall follow procedures  
 31 consistent with the provisions of ORS chapter 183 relating to a contested case.

32        (6) Once a certificate of need has been issued, [*it*] **the certificate of need** may not be revoked  
 33 or rescinded unless it was acquired by fraud or deceit. However, if the [*authority*] **department** finds  
 34 that a person is offering or developing a project that is not within the scope of the certificate of  
 35 need, the [*authority*] **department** may limit the project as specified in the issued certificate of need  
 36 or reconsider the application. A certificate of need is not transferable.

37        (7) Nothing in this section applies to any [*hospital,*] skilled nursing or intermediate care service  
 38 or facility that seeks to replace equipment with equipment of similar basic technological function  
 39 or an upgrade that improves the quality or cost-effectiveness of the service provided. Any person  
 40 acquiring such replacement or upgrade shall file a letter of intent for the project in accordance with  
 41 the rules of the [*authority*] **department** if the price of the replacement equipment or upgrade ex-  
 42 ceeds \$1 million.

43        [(8) *Except as required in subsection (1) of this section for a new hospital or new skilled nursing*  
 44 *or intermediate care service or facility not operating as a Medicare swing bed program, nothing in this*  
 45 *section requires a rural hospital as defined in ORS 442.470 (6)(a)(A) and (B) to obtain a certificate of*



1 need.]

2 [(9) Nothing in this section applies to basic health services, but basic health services do not  
3 include:]

- 4 [(a) Magnetic resonance imaging scanners;]
- 5 [(b) Positron emission tomography scanners;]
- 6 [(c) Cardiac catheterization equipment;]
- 7 [(d) Megavoltage radiation therapy equipment;]
- 8 [(e) Extracorporeal shock wave lithotriptors;]
- 9 [(f) Neonatal intensive care;]
- 10 [(g) Burn care;]
- 11 [(h) Trauma care;]
- 12 [(i) Inpatient psychiatric services;]
- 13 [(j) Inpatient chemical dependency services;]
- 14 [(k) Inpatient rehabilitation services;]
- 15 [(L) Open heart surgery; or]
- 16 [(m) Organ transplant services.]

17 [(10)] (8) In addition to any other remedy provided by law, whenever it appears that any person  
18 is engaged in, or is about to engage in, any acts that constitute a violation of this section, or any  
19 rule or order issued by the [authority] **department** under this section, the [authority] **department**  
20 may institute proceedings in the circuit courts to enforce obedience to such statute, rule or order  
21 by injunction or by other processes, mandatory or otherwise.

22 [(11) As used in this section, “basic health services” means health services offered in or through  
23 a hospital licensed under ORS chapter 441, except skilled nursing or intermediate care nursing facili-  
24 ties or services and those services specified in subsection (9) of this section.]

25 **SECTION 22.** ORS 442.362 is amended to read:

26 442.362. The Oregon Health Authority may adopt rules requiring reporting entities within the  
27 state to publicly report proposed capital projects **to the Regional Planning Boards established**  
28 **under section 16 of this 2019 Act.** Rules adopted under this section must:

29 (1) Require a reporting entity to establish on the home page of its website a prominently labeled  
30 link to information about proposed or pending capital projects. The information posted must include  
31 but is not limited to a report of the community benefit for the project, its estimated cost and a  
32 means for interested persons to submit comments. When a reporting entity posts the information  
33 required under this subsection, the reporting entity must notify the [authority] **Regional Planning**  
34 **Board** of the posting in the manner prescribed by the authority.

35 (2) If a reporting entity does not have a website, require the reporting entity to publish notice  
36 of the proposed capital project in a major newspaper or online equivalent serving the region in  
37 which the proposed capital project will be located. The notice must include but is not limited to a  
38 report of the community benefit for the project, its estimated cost and a means for interested per-  
39 sons to submit comments. When a reporting entity publishes the information required under this  
40 subsection, the reporting entity must notify the [authority] **Regional Planning Board** of the publi-  
41 cation in the manner prescribed by the authority.

42 (3) Establish a publicly available resource for information collected under this section.

43  
44 **TRANSITION COMMISSION**  
45

1       **SECTION 23.** (1) There is established a Transition Commission consisting of seven mem-  
2       bers appointed by the Governor from individuals recommended by health care providers and  
3       health care consumer advocacy organizations. Collectively, the members must have exten-  
4       sive experience and knowledge in:

- 5       (a) Health care delivery, planning, financing and administration;
- 6       (b) Health economics; and
- 7       (c) Public finance and administration.

8       (2) The commission shall advise and assist the Health Care for All Oregon Board in de-  
9       signing and implementing the Health Care for All Oregon Plan, including advice and assist-  
10      ance regarding the following:

- 11      (a) Developing an effective and efficient administrative structure to implement the plan.
- 12      (b) Proposing simple application procedures to promote timely access to health care.
- 13      (c) Designing a quality assurance system.
- 14      (d) Developing policies and procedures to ensure fair and adequate compensation for  
15      health care providers and to create incentives to expand the availability of primary care. In  
16      developing these policies and procedures, the commission shall encourage the full partic-  
17      ipation of health care providers and consumer advocacy organizations.
- 18      (e) Proposing a cost-effective, transparent and accountable method for financing the  
19      plan, including measures to detect and reduce fraud.

20      (f) Advising the board on:

- 21      (A) The integration of information systems;
  - 22      (B) The integration of physical, mental and dental health services;
  - 23      (C) Negotiations with the federal government to obtain necessary waivers of federal laws;
- 24      and

25      (D) The implementation of a program to retrain displaced workers in accordance with  
26      section 10 of this 2019 Act. The program shall include coordination with appropriate state  
27      agencies and nonprofit organizations.

28      (g) Developing recommendations to resolve the tension between the ideal of a medical  
29      home and the ideal of freedom to choose one's health care provider.

30      (h) Developing recommendations with respect to the impact on employee wages with the  
31      implementation of the plan and policies to ensure fair wages and salaries given the impact  
32      of the plan.

33      (i) Determining, in collaboration with the Health Care for All Oregon Board and the  
34      Oregon Health Policy Board, how to merge or complement the functions of the boards.

35      (j) As deemed necessary by the Health Care for All Oregon Board, reporting to the Leg-  
36      islative Assembly on the progress in establishing the administrative structure, rules and  
37      procedures for the plan.

38      (3) All appointments to the commission must be completed by the Governor no later than  
39      90 days after the effective date of this 2019 Act.

40      (4) A majority of the members of the commission constitutes a quorum for the trans-  
41      action of business.

42      (5) Official action by the commission requires the approval of a majority of the members  
43      of the commission.

44      (6) The commission shall elect one of its members to serve as chairperson and one of its  
45      members to serve as vice chairperson.

1 (7) If there is a vacancy for any cause, the Governor shall make an appointment to be-  
 2 come immediately effective.

3 (8) The commission shall meet regularly at times and places specified by the call of the  
 4 chairperson, the Health Care for All Oregon Board or a majority of the members of the  
 5 commission.

6 (9) The commission may adopt rules necessary for the operation of the commission.

7 (10) Members of the commission are entitled to compensation and expenses fixed by the  
 8 board and paid out of funds appropriated to the board for the purposes of the commission.

9 (11) The Oregon Health Authority shall provide staff support to the commission.

10 (12) The Governor shall dissolve the commission when its work is completed, but no later  
 11 than December 31, 2023.

12 (13) All agencies of state government, as defined in ORS 174.111, are directed to assist  
 13 the commission in the performance of its duties and, to the extent permitted by laws relating  
 14 to confidentiality, to furnish such information and advice as the members of the commission  
 15 consider necessary to perform their duties.

16 **SECTION 24.** The Oregon Health Authority may apply to any circuit court for an order  
 17 compelling compliance with any rule adopted by the Health Care for All Oregon Board under  
 18 sections 5, 7, 9 and 11 of this 2019 Act. If the court finds that the defendant is not complying  
 19 with any rule so adopted, the court shall grant an injunction requiring compliance. The  
 20 court, on motion and affidavits, may grant a preliminary injunction ex parte upon such  
 21 terms as are just. The authority need not give security before the issuance of an injunction  
 22 under this section.

23 **SECTION 25.** (1) In addition to any other liability or penalty provided by law, the Director  
 24 of the Oregon Health Authority may impose a civil penalty on a person for violation of any  
 25 rule or general order of the Health Care for All Oregon Board or Oregon Health Authority  
 26 adopted or issued in accordance with sections 5, 7, 9 and 11 of this 2019 Act.

27 (2) A civil penalty imposed under this section may be remitted or reduced upon such  
 28 terms and conditions as the director considers proper.

29 (3) All penalties recovered under this section shall be paid into the State Treasury and  
 30 credited to the Health Care for All Oregon Fund.

31  
 32 **PUBLIC EMPLOYEE PARTICIPATION IN**  
 33 **THE HEALTH CARE FOR ALL OREGON PLAN**  
 34 **(Public Employees' Benefit Board)**  
 35

36 **SECTION 26.** ORS 238.538 is amended to read:

37 238.538. (1) A judge member who elects to retire under ORS 238.535 (1)(b):

38 (a) Shall continue to be eligible as a nonretired employee for **supplemental** health benefit plans  
 39 contracted for under ORS 243.135 during the time that the judge member is serving as a pro tem  
 40 judge under ORS 238.535 (1)(c); and

41 (b) Subject to availability of funding, shall continue to receive the monthly state contribution  
 42 as payment of all or part of the cost of a **supplemental** health benefit plan during the time that the  
 43 judge member is serving as a pro tem judge under ORS 238.535 (1)(c).

44 (2) A judge member receiving the monthly state contribution as payment of all or part of the  
 45 cost of a **supplemental** health benefit plan under this section is not eligible for payments against

1 the cost of Medicare supplemental insurance under ORS 238.420 until such time as the judge member  
2 is no longer serving as a pro tem judge under ORS 238.535 (1)(c).

3 **SECTION 27.** ORS 243.105 is amended to read:

4 243.105. As used in ORS 243.105 to 243.285, unless the context requires otherwise:

5 (1) "Benefit plan" includes, but is not limited to:

6 (a) Contracts for insurance or other benefits, including **supplemental** medical, dental[,] **or** vi-  
7 sion, life[, *disability and other health care recognized by state law, and related services and*  
8 *supplies;*] **or disability insurance or other benefits; and**

9 [*(b) Comparable benefits for employees who rely on spiritual means of healing; and*]

10 [*(c) Self-insurance programs managed by the Public Employees' Benefit Board.*]

11 **(b) The Health Care for All Oregon Plan or comparable benefits for employees who rely**  
12 **on spiritual means of healing.**

13 (2) "Board" means the Public Employees' Benefit Board.

14 (3) "Carrier" means an insurance company or health care service contractor holding a valid  
15 certificate of authority from the Director of the Department of Consumer and Business Services, or  
16 two or more companies or contractors acting together pursuant to a joint venture, partnership or  
17 other joint means of operation, or a board-approved guarantor of benefit plan coverage and com-  
18 pensation.

19 (4)(a) "Eligible employee" means an officer or employee of a state agency or local government  
20 who elects to participate in one of the [*group*] **supplemental health** benefit plans described in ORS  
21 243.135. [*The term*]

22 **(b) "Eligible employee"** includes, but is not limited to, state officers and employees in the ex-  
23 empt, unclassified and classified service, and state officers and employees, whether or not retired,  
24 who:

25 (A) Are receiving a service retirement allowance, a disability retirement allowance or a pension  
26 under the Public Employees Retirement System or are receiving a service retirement allowance, a  
27 disability retirement allowance or a pension under any other retirement or disability benefit plan  
28 or system offered by the State of Oregon for its officers and employees;

29 (B) Are eligible to receive a service retirement allowance under the Public Employees Retire-  
30 ment System and have reached earliest retirement age under ORS chapter 238;

31 (C) Are eligible to receive a pension under ORS 238A.100 to 238A.250, and have reached earliest  
32 retirement age as described in ORS 238A.165; or

33 (D) Are eligible to receive a service retirement allowance or pension under another retirement  
34 benefit plan or system offered by the State of Oregon and have attained earliest retirement age  
35 under the plan or system.

36 [*(b)*] **(c) "Eligible employee"** does not include individuals:

37 (A) Engaged as independent contractors;

38 (B) Whose periods of employment in emergency work are on an intermittent or irregular basis;

39 (C) Who are employed on less than half-time basis unless the individuals are employed in posi-  
40 tions classified as job-sharing positions, unless the individuals are defined as eligible under rules of  
41 the board;

42 (D) Appointed under ORS 240.309;

43 (E) Provided sheltered employment or make-work by the state in an employment or industries  
44 program maintained for the benefit of such individuals;

45 (F) Provided student health care services in conjunction with their enrollment as students at a

1 public university listed in ORS 352.002; or

2 (G) Who are members of a collective bargaining unit that represents police officers or fire-  
3 fighters.

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

7 (6) "Local government" means any city, county or special district in this state or any intergov-  
8 ernmental entity created under ORS chapter 190.

9 (7) "Payroll disbursing officer" means the officer or official authorized to disburse moneys in  
10 payment of salaries and wages of employees of a state agency or local government.

11 (8) "Premium" means the monthly or other periodic charge for a benefit plan.

12 [(9) "*Primary care*" means family medicine, general internal medicine, naturopathic medicine,  
13 obstetrics and gynecology, pediatrics or general psychiatry.]

14 [(10)] (9) "State agency" means every state officer, board, commission, department or other ac-  
15 tivity of state government.

16 [(11) "*Total medical expenditures*" means payments to reimburse the cost of physical and mental  
17 health care provided to eligible employees or their family members, excluding prescription drugs, vision  
18 care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type  
19 of payment mechanism.]

20 **SECTION 28.** ORS 243.107 is amended to read:

21 243.107. A person employed by a public university listed in ORS 352.002 or the Oregon Health  
22 and Science University may be considered an eligible employee for participation in one of the  
23 [group] **supplemental health** benefit plans described in ORS 243.135 if the governing board of the  
24 public university, or the Oregon Health and Science University Board of Directors for Oregon  
25 Health and Science University employees, determines that funds are available therefor and if:

26 (1) Notwithstanding ORS 243.105 [(4)(b)(F)] **(4)(c)(F)**, the person is a student enrolled in an in-  
27 stitution of higher education and is employed as a graduate teaching assistant, graduate research  
28 assistant or a fellow at the institution and elects to participate; or

29 (2) Notwithstanding ORS 243.105 [(4)(b)(B) or (C)] **(4)(c)(B) or (C)**, the person is employed on a  
30 less than half-time basis in an unclassified instructional or research support capacity and elects to  
31 participate.

32 **SECTION 29.** ORS 243.125 is amended to read:

33 243.125. (1) The Public Employees' Benefit Board shall prescribe rules for the conduct of its  
34 business and for carrying out ORS 243.256. The board shall study all matters connected with the  
35 providing of adequate benefit plan coverage for eligible employees on the best basis possible with  
36 relation both to the welfare of the employees and to the state and local governments. The board  
37 shall design benefits, devise specifications, analyze carrier responses to advertisements for bids and  
38 decide on the award of contracts. Contracts shall be signed by the chairperson on behalf of the  
39 board.

40 (2) In carrying out its duties under subsection (1) of this section, the goal of the board shall be  
41 to provide [*a high quality plan of health and other benefits*] **high quality benefit plans** for employees  
42 at a cost affordable to both the employer and the employees.

43 (3) Subject to ORS chapter 183, the board may make rules not inconsistent with ORS 243.105 to  
44 243.285 and 292.051 to determine the terms and conditions of eligible employee participation and  
45 coverage.

1 (4)(a) The board shall prepare specifications, invite bids and do acts necessary to award con-  
 2 tracts for **supplemental** health benefit plan and **supplemental** dental benefit plan coverage of eli-  
 3 gible employees in accordance with the criteria set forth in ORS 243.135 [(1)] (2).

4 [(b) Premium rates established by the board for a self-insured health benefit plan and premium  
 5 rates negotiated by the board with a carrier that offers a health benefit plan to eligible employees must  
 6 take into account any reduction in the cost of hospital services and supplies anticipated to result from  
 7 the application of ORS 243.256.]

8 (5) The executive director of the board shall report to the Director of the Oregon Health Au-  
 9 thority.

10 (6) The board may retain consultants, brokers or other advisory personnel when necessary and,  
 11 subject to the State Personnel Relations Law, shall employ such personnel as are required to per-  
 12 form the functions of the board. [If the board contracts for actuarial or technical support to manage  
 13 the functions of the board, the board shall, no less than every three years, solicit invitations to bid and  
 14 the proposals must include all of the following:]

15 [(a) An explanation of how the bidder has assisted other clients in creating incentives to improve  
 16 the quality of care provided to enrollees;]

17 [(b) An explanation of how the bidder will support the board's efforts to maximize provider effi-  
 18 ciencies and achieve more organized systems of care; and]

19 [(c) A description of the bidder's experience in assisting other clients in structuring contracts that  
 20 use risk-based networks of providers and alternative provider reimbursement methodologies.]

21 **SECTION 30.** ORS 243.129 is amended to read:

22 243.129. (1) The governing body of a local government may elect to participate in a benefit plan  
 23 offered by the Public Employees' Benefit Board.

24 (2) The decision of the governing body of a local government to participate in a benefit plan  
 25 offered by the board is in the discretion of the governing body of the local government and is a  
 26 permissive subject of collective bargaining.

27 [(3) If the governing body of a local government elects to offer a benefit plan through the board,  
 28 the governing body may elect one time only to provide alternative group health and welfare insurance  
 29 benefit plans to eligible employees if:]

30 [(a) The alternative benefit plan is offered through the health insurance exchange under ORS  
 31 741.310 (1)(b); and]

32 [(b) The participation of the local government is not precluded under federal law on or after Jan-  
 33 uary 1, 2017.]

34 **SECTION 31.** ORS 243.135 is amended to read:

35 243.135. (1) **Any person who is eligible to enroll in a benefit plan available to state em-**  
 36 **ployees pursuant to ORS 243.105 to 243.285 and 292.051 shall participate in the Health Care**  
 37 **for All Oregon Plan.**

38 [(1)] (2) [Notwithstanding any other benefit plan contracted for and offered by the Public  
 39 Employees' Benefit Board] **If the Public Employees' Benefit Board contracts for health benefit**  
 40 **plans to supplement the coverage provided in Health Care for All Oregon Plan,** the board shall  
 41 contract for a **supplemental** health benefit plan or plans best designed to meet the needs and pro-  
 42 vide for the welfare of eligible employees, the state and the local governments. In considering  
 43 whether to enter into a contract for a **supplemental health benefit** plan, the board shall place  
 44 emphasis on:

45 (a) Employee choice among high quality plans;

- 1 (b) A competitive marketplace;  
 2 (c) Plan performance and information;  
 3 (d) Employer flexibility in plan design and contracting;  
 4 (e) Quality customer service;  
 5 (f) Creativity and innovation;  
 6 (g) Plan benefits as part of total employee compensation;  
 7 (h) The improvement of employee health; and  
 8 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the  
 9 **supplemental health benefit** plan.

10 [(2)] (3) The board may approve more than one carrier for each type of **supplemental health**  
 11 **benefit** plan contracted for and offered, but the number of carriers shall be held to a number con-  
 12 sistent with adequate service to eligible employees and their family members.

13 [(3)] (4) Where appropriate for a contracted and offered **supplemental** health benefit plan, the  
 14 board shall provide options under which an eligible employee may arrange coverage for family  
 15 members.

16 [(4)] (5) Payroll deductions for costs that are not payable by the state or a local government  
 17 may be made upon receipt of a signed authorization from the employee indicating an election to  
 18 participate in the **supplemental health benefit** plan or plans selected and the deduction of a cer-  
 19 tain sum from the employee's pay.

20 [(5)] (6) In developing any **supplemental** health benefit plan, the board may provide an option  
 21 of additional coverage for eligible employees and their family members at an additional cost or  
 22 premium.

23 [(6)] (7) Transfer of enrollment from one **supplemental health benefit** plan to another shall be  
 24 open to all eligible employees and their family members under rules adopted by the board. *[Because*  
 25 *of the special problems that may arise in individual instances under comprehensive group practice plan*  
 26 *coverage involving acceptable provider-patient relations between a particular panel of providers and*  
 27 *particular eligible employees and their family members, the board shall provide a procedure under*  
 28 *which any eligible employee may apply at any time to substitute a health service benefit plan for par-*  
 29 *ticipation in a comprehensive group practice benefit plan.]*

30 [(7)] (8) The board shall evaluate a **supplemental health** benefit plan that serves a limited ge-  
 31 ographic region of this state according to the criteria described in subsection [(1)] (2) of this section.

32 [(8) *By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures*  
 33 *in self-insured health benefit plans on payments for primary care.]*

34 [(9) *No later than February 1 of each year, the board shall report to the Legislative Assembly on*  
 35 *the board's progress toward achieving the target of spending at least 12 percent of total medical*  
 36 *expenditures in self-insured health benefit plans on payments for primary care.]*

37 **SECTION 32.** ORS 243.135, as amended by section 27, chapter 746, Oregon Laws 2017, is  
 38 amended to read:

39 243.135. (1) **Any person who is eligible to enroll in a benefit plan available to state em-**  
 40 **ployees pursuant to ORS 243.105 to 243.285 and 292.051 shall participate in the Health Care**  
 41 **for All Oregon Plan.**

42 [(1)] (2) *[Notwithstanding any other benefit plan contracted for and offered by the Public*  
 43 *Employees' Benefit Board]* **If the Public Employees' Benefit Board contracts for health benefit**  
 44 **plans to supplement the coverage provided in Health Care for All Oregon Plan,** the board shall  
 45 contract for a **supplemental** health benefit plan or plans best designed to meet the needs and pro-

1 vide for the welfare of eligible employees, the state and the local governments. In considering  
 2 whether to enter into a contract for a **supplemental health benefit** plan, the board shall place  
 3 emphasis on:

4 (a) Employee choice among high quality plans;

5 (b) A competitive marketplace;

6 (c) Plan performance and information;

7 (d) Employer flexibility in plan design and contracting;

8 (e) Quality customer service;

9 (f) Creativity and innovation;

10 (g) Plan benefits as part of total employee compensation;

11 (h) The improvement of employee health; and

12 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the  
 13 **supplemental health benefit** plan.

14 [(2)] (3) The board may approve more than one carrier for each type of **supplemental health**  
 15 **benefit** plan contracted for and offered, but the number of carriers shall be held to a number con-  
 16 sistent with adequate service to eligible employees and their family members.

17 [(3)] (4) Where appropriate for a contracted and offered **supplemental** health benefit plan, the  
 18 board shall provide options under which an eligible employee may arrange coverage for family  
 19 members who are not enrolled in another health benefit plan offered by the board or the Oregon  
 20 Educators Benefit Board. An eligible employee who declines coverage in a **supplemental** health  
 21 benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board  
 22 and who is enrolled as a spouse or family member in another **supplemental** health benefit plan of-  
 23 fered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board may not be  
 24 paid the employer contribution for the plan that was declined.

25 [(4)] (5) Payroll deductions for costs that are not payable by the state or a local government  
 26 may be made upon receipt of a signed authorization from the employee indicating an election to  
 27 participate in the **supplemental health benefit** plan or plans selected and the deduction of a cer-  
 28 tain sum from the employee's pay.

29 [(5)] (6) In developing any **supplemental** health benefit plan, the board may provide an option  
 30 of additional coverage for eligible employees and their family members at an additional cost or  
 31 premium.

32 [(6)] (7) Transfer of enrollment from one **supplemental health benefit** plan to another shall be  
 33 open to all eligible employees and their family members under rules adopted by the board. *[Because*  
 34 *of the special problems that may arise in individual instances under comprehensive group practice plan*  
 35 *coverage involving acceptable provider-patient relations between a particular panel of providers and*  
 36 *particular eligible employees and their family members, the board shall provide a procedure under*  
 37 *which any eligible employee may apply at any time to substitute a health service benefit plan for par-*  
 38 *ticipation in a comprehensive group practice benefit plan.]*

39 [(7)] (8) The board shall evaluate a **supplemental health** benefit plan that serves a limited ge-  
 40 ographic region of this state according to the criteria described in subsection [(1)] (2) of this section.

41 [(8)(a)] *The board shall use payment methodologies in self-insured health benefit plans offered by*  
 42 *the board that are designed to limit the growth in per-member expenditures for health services to no*  
 43 *more than 3.4 percent per year.]*

44 [(b)] *The board shall adopt policies and practices designed to limit the annual increase in premium*  
 45 *amounts paid for contracted health benefit plans to 3.4 percent.]*



1        [(9) A carrier or third party administrator that contracts with the board to provide or administer  
2 a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan  
3 enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would  
4 affect the cost of the premium for the plan.]

5        [(10) By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures  
6 in self-insured health benefit plans on payments for primary care.]

7        [(11) No later than February 1 of each year, the board shall report to the Legislative Assembly on  
8 the board's progress toward achieving the target of spending at least 12 percent of total medical  
9 expenditures in self-insured health benefit plans on payments for primary care.]

10        **SECTION 33.** ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, and  
11 section 27, chapter 746, Oregon Laws 2017, is amended to read:

12        243.135. (1) **Any person who is eligible to enroll in a benefit plan available to state em-**  
13 **ployees pursuant to ORS 243.105 to 243.285 and 292.051 shall participate in the Health Care**  
14 **for All Oregon Plan.**

15        [(1)] (2) [Notwithstanding any other benefit plan contracted for and offered by the Public  
16 Employees' Benefit Board] **If the Public Employees' Benefit Board contracts for health benefit**  
17 **plans to supplement the coverage provided in Health Care for All Oregon Plan,** the board shall  
18 contract for a **supplemental** health benefit plan or plans best designed to meet the needs and pro-  
19 vide for the welfare of eligible employees, the state and the local governments. In considering  
20 whether to enter into a contract for a **supplemental health benefit** plan, the board shall place  
21 emphasis on:

22        (a) Employee choice among high quality plans;

23        (b) A competitive marketplace;

24        (c) Plan performance and information;

25        (d) Employer flexibility in plan design and contracting;

26        (e) Quality customer service;

27        (f) Creativity and innovation;

28        (g) Plan benefits as part of total employee compensation;

29        (h) The improvement of employee health; and

30        (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the  
31 **supplemental health benefit** plan.

32        [(2)] (3) The board may approve more than one carrier for each type of **supplemental health**  
33 **benefit** plan contracted for and offered, but the number of carriers shall be held to a number con-  
34 sistent with adequate service to eligible employees and their family members.

35        [(3)] (4) Where appropriate for a contracted and offered **supplemental** health benefit plan, the  
36 board shall provide options under which an eligible employee may arrange coverage for family  
37 members who are not enrolled in another health benefit plan offered by the board or the Oregon  
38 Educators Benefit Board. An eligible employee who declines coverage in a **supplemental** health  
39 benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board  
40 and who is enrolled as a spouse or family member in another **supplemental** health benefit plan of-  
41 fered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board may not be  
42 paid the employer contribution for the plan that was declined.

43        [(4)] (5) Payroll deductions for costs that are not payable by the state or a local government  
44 may be made upon receipt of a signed authorization from the employee indicating an election to  
45 participate in the **supplemental health benefit** plan or plans selected and the deduction of a cer-

tain sum from the employee's pay.

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

[(6)] (7) Transfer of enrollment from one **supplemental health benefit** plan to another shall be open to all eligible employees and their family members under rules adopted by the board. *[Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.]*

[(7)] (8) The board shall evaluate a **supplemental health** benefit plan that serves a limited geographic region of this state according to the criteria described in subsection [(1)] (2) of this section.

[(8)(a)] *The board shall use payment methodologies in self-insured health benefit plans offered by the board that are designed to limit the growth in per-member expenditures for health services to no more than 3.4 percent per year.*

[(b)] *The board shall adopt policies and practices designed to limit the annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.*

[(9)] *A carrier or third party administrator that contracts with the board to provide or administer a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.*

[(10)] *If the board spends less than 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care, the board shall implement a plan for increasing the percentage of total medical expenditures spent on payments for primary care by at least one percent each year.*

[(11)] *No later than February 1 of each year, the board shall report to the Legislative Assembly on any plan implemented under subsection (10) of this section and on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care.*

**SECTION 34.** ORS 243.140 is amended to read:

243.140. (1) Persons whose homes are certified as a foster home by the Department of Human Services under ORS 418.630 and as defined in ORS 418.625 (3) may participate in a **supplemental** health benefit plan available to employees pursuant to ORS 243.105 to 243.285 at the expense of the foster parent. For such purposes, foster parents shall be considered eligible employees.

(2) A person who maintains a developmental disability child foster home that is certified by the department under ORS 443.830 and 443.835 may participate in a **supplemental** health benefit plan available to employees pursuant to ORS 243.105 to 243.285 at the expense of the person. For such purposes, the person maintaining the home shall be considered an eligible employee.

[(3)] *Persons who participate in the health benefit plan pursuant to subsections (1) and (2) of this section may also participate in a dental plan available to employees pursuant to ORS 243.105 to 243.285 at the expense of the foster parent or the person maintaining the developmental disability child foster home.*

**SECTION 35.** ORS 243.160 is amended to read:

243.160. A retired state or local government officer or employee is not required to participate

1 in one of the *[group]* **supplemental health** benefit plans described in ORS 243.135 in order to obtain  
 2 **supplemental** dental benefit plan coverage. The Public Employees' Benefit Board shall establish by  
 3 rule standards of eligibility for retired officers or employees to participate in a **supplemental** dental  
 4 benefit plan.

5 **SECTION 36.** ORS 243.163 is amended to read:

6 243.163. A member of the Legislative Assembly who is receiving a pension or annuity under ORS  
 7 238.092 (1)(a) or 238A.250 (1) shall be eligible to participate as a retired state officer in one of the  
 8 *[group]* **supplemental health** benefit plans described in ORS 243.135 after the member ceases to be  
 9 a member of the Legislative Assembly if the member applies to the Public Employees' Benefit Board  
 10 within 60 days after the member ceases to be a member of the Legislative Assembly.

11 **SECTION 37.** ORS 243.185 is amended to read:

12 243.185. Subject to legislative or Emergency Board approval of budgetary authorization for op-  
 13 eration of the Public Employees' Benefit Board and its administration of the *[health]* benefit plans  
 14 and other duties under ORS 243.105 to 243.285 and 292.051, an amount not to exceed two percent  
 15 of the employer and employee contributions shall be forwarded by each payroll disbursing officer to  
 16 the board and deposited by it in the State Treasury to the credit of the Public Employees' Benefit  
 17 Account to meet administrative and other costs authorized by ORS 243.105 to 243.285 and 292.051.  
 18 The board shall take action to ensure that the balance in the account does not exceed five percent  
 19 of the monthly total of employer and employee contributions for more than 120 days.

20 **SECTION 38.** ORS 243.215 is amended to read:

21 243.215. Any eligible employee unable to participate in one or more of the **benefit** plans de-  
 22 scribed in ORS 243.135 *[(1)]* solely because the employee is assigned to perform duties outside the  
 23 state may be eligible to receive the monthly state or local government contribution, less adminis-  
 24 trative expenses, as payment of all or part of the cost of a *[health]* benefit plan of choice, subject  
 25 to the approval of the Public Employees' Benefit Board and such rules as the board may adopt.

26 **SECTION 39.** ORS 243.221 is amended to read:

27 243.221. (1) In addition to the powers and duties otherwise provided by law to provide employee  
 28 benefits, the Public Employees' Benefit Board may provide, administer and maintain flexible benefit  
 29 plans under which eligible employees may choose among taxable and nontaxable benefits as provided  
 30 in the federal Internal Revenue Code.

31 (2) In providing flexible benefit plans, the board may offer:

32 (a) **Supplemental** health or dental benefits as provided in ORS 243.125 and 243.135.

33 (b) *[Other insurance benefits]* **Benefit plans** as provided in ORS 243.275.

34 (c) Dependent care assistance as provided in ORS 243.550.

35 (d) Expense reimbursement as provided in ORS 243.560.

36 (e) Any other benefit that may be excluded from an employee's gross income under the federal  
 37 Internal Revenue Code.

38 (f) Any part or all of the state or local government contribution for employee benefits in cash  
 39 to the employee.

40 (3) In developing flexible benefit plans under this section, the board shall design the plan on the  
 41 best basis possible with relation to the welfare of employees, the state and the local governments.

42 **SECTION 40.** ORS 243.275 is amended to read:

43 243.275. (1) *[In addition to contracting for health and dental benefit plans,]* The Public Employees'  
 44 Benefit Board may contract with carriers to provide at the expense of participating eligible em-  
 45 ployees and with or without state or local government participation for coverage, **benefit plans**

1 including but not limited to, insurance or other benefit based on life, supplemental medical, supple-  
2 mental dental, *[optical]* **supplemental vision**, accidental death or disability insurance plans.

3 (2) The monthly contribution of each eligible employee for *[other benefit plan or plans coverage,*  
4 *as]* **a benefit plan** described in subsection (1) of this section, shall be the total cost per month of  
5 the *[benefit]* coverage afforded the employee under the plan *[or plans]*, for which the employee ex-  
6 ercises an option, including the cost of enrollment and administrative expenses **for the plan**.

7 (3) For any benefit plan *[or plans]* described in subsection (1) of this section in which the state  
8 or a local government participates, the monthly contribution of each eligible employee for the ben-  
9 efit plan, for which the employee exercises an option and there is state or local government partic-  
10 ipation, shall be reduced by an amount equal to the portion contributed by the state or the local  
11 government, including the cost of enrollment and administrative expenses.

12 (4) The board may withdraw approval of any such additional benefit plan coverage in the same  
13 manner as *[it]* **the board** withdraws approval *[of health benefit plans as described and authorized*  
14 *by]* **under** ORS 243.145.

15 (5) If any state agency or local government contracts for any of the *[benefits]* **benefit plans**  
16 described in subsection (1) of this section on behalf of any eligible employees, the administrative  
17 expenses of the contract shall be paid by assessment of the participating employees. The contracts  
18 are subject to approval of the board before *[they]* **the contracts** become operative. The board may  
19 withdraw approval for any such benefit in the same manner as *[it]* **the board** withdraws approval  
20 under ORS 243.145.

21 **SECTION 41.** ORS 243.285 is amended to read:

22 243.285. (1) Upon receipt of the request in writing of an eligible employee so to do, the payroll  
23 disbursing officer authorized to disburse funds in payment of the salary or wages of the eligible  
24 employee may deduct from the salary or wages of the employee an amount of money indicated in the  
25 request for payment of the applicable amount set forth in benefit plans selected by the employee or  
26 selected on the employee's behalf for[.]

27 *[(a) Group health and related services and supplies, including such insurance for family members*  
28 *of the eligible employee.]*

29 *[(b) Group life insurance, including life insurance for family members of the eligible employee.]*

30 *[(c) Group dental and related services and supplies, or any other remedial care recognized by state*  
31 *law and related services and supplies, recognized under state law, including such insurance for family*  
32 *members of the eligible employee.]*

33 *[(d) Group indemnity insurance for accidental death and dismemberment and for loss of income*  
34 *due to accident, sickness or other disability, including such insurance for family members of the eligible*  
35 *employee.]*

36 *[(e) Other] benefits[, including self-insurance programs,]* that are approved and provided by the  
37 Public Employees' Benefit Board.

38 (2) Moneys deducted under subsection (1) of this section shall be paid over promptly[.]

39 *[(a)]* to the carriers or persons responsible for payment of premiums to carriers, in accordance  
40 with the terms of the contracts made by the eligible employees or on their behalf[; or].

41 *[(b) With respect to self-insurance benefits, in accordance with rules, procedures and directions of*  
42 *the Public Employees' Benefit Board.]*

43 **SECTION 42.** ORS 292.051 is amended to read:

44 292.051. (1) Except as authority over contracts for **supplemental** health benefit plans described  
45 in ORS 243.135 is vested in the Public Employees' Benefit Board, upon receipt of the request in

1 writing of an officer or employee so to do, the state official authorized to disburse funds in payment  
 2 of the salary or wages of the officer or employee may deduct from the salary or wages of the officer  
 3 or employee an amount of money indicated in the request for payment of the applicable amount set  
 4 forth in benefit plans selected by the officers or employees or in their behalf for:

5 (a) Group life insurance, including life insurance for dependents of officers or employees.

6 (b) *[Group]* **Supplemental** dental and related services and supplies, or any other remedial care  
 7 recognized by state law and related services and supplies, other than medical, surgical or hospital  
 8 care, recognized under state law, including such insurance for dependents of state officers or em-  
 9 ployees.

10 (c) Group indemnity insurance for accidental death and dismemberment and for loss of income  
 11 due to accident, sickness or other disability, including such insurance for dependents of state offi-  
 12 cers or employees.

13 (d) Automobile casualty insurance under a monthly payroll deduction program endorsed or of-  
 14 fered by an employee organization representing 500 or more state employees. Membership in the  
 15 employee organization is not a requirement for participation in this program.

16 (e) Legal insurance under a monthly payroll deduction program endorsed or offered by an em-  
 17 ployee organization representing 500 or more state employees.

18 *[(f) Self-insurance programs that are approved and provided by the Public Employees' Benefit*  
 19 *Board.]*

20 (2) The Oregon Health Authority may establish and collect a fee to cover costs of administering  
 21 this section.

22 (3) No state official authorized to disburse funds in payment of salaries or wages is required to  
 23 make deductions as authorized by subsection (1) of this section for more than one benefit plan of the  
 24 type referred to in each of the paragraphs in subsection (1) of this section per eligible employee.

25 (4) Moneys deducted under subsection (1) of this section shall be paid over promptly[:]

26 *[(a)]* to the insurance companies, agencies or hospital associations, or persons responsible for  
 27 payment of premiums to the companies, agencies or associations, in accordance with the terms of  
 28 the contracts made by the officers or employees or in their behalf; *or].*

29 *[(b) With respect to self-insurance benefits, in accordance with rules, procedures and directions of*  
 30 *the Public Employees' Benefit Board.]*

31 (5) As used in this section, "officer or employee" means all persons who receive salaries or  
 32 wages disbursed by any state official.

### 33 (Oregon Educators Benefit Board)

34  
 35  
 36 **SECTION 43.** ORS 243.860 is amended to read:

37 243.860. As used in ORS 243.860 to 243.886, unless the context requires otherwise:

38 (1) "Benefit plan" includes but is not limited to:

39 (a) Contracts for insurance or other benefits, including **supplemental** medical, dental[,] **or** vi-  
 40 sion, life[, *disability and other health care recognized by state law, and related services and*  
 41 *supplies;]* **or disability insurance or other benefits; and**

42 *[(b) Self-insurance programs managed by the Oregon Educators Benefit Board; and]*

43 *[(c) Comparable benefits for employees who rely on spiritual means of healing.]*

44 **(b) The Health Care for All Oregon Plan or comparable benefits for employees who rely**  
 45 **on spiritual means of healing.**

1 (2) “Carrier” means an insurance company or health care service contractor holding a valid  
 2 certificate of authority from the Director of the Department of Consumer and Business Services, or  
 3 two or more companies or contractors acting together pursuant to a joint venture, partnership or  
 4 other joint means of operation, or a board-approved provider or guarantor of benefit plan coverage  
 5 and compensation.

6 (3) “District” means a common school district, a union high school district, an education service  
 7 district, as defined in ORS 334.003, or a community college district, as defined in ORS 341.005.

8 (4)(a) “Eligible employee” includes:

9 (A) An officer or employee of a district or a local government who elects to participate in one  
 10 of the benefit plans described in ORS 243.864 to 243.874; and

11 (B) An officer or employee of a district or a local government, whether or not retired, who:

12 (i) Is receiving a service retirement allowance, a disability retirement allowance or a pension  
 13 under the Public Employees Retirement System or is receiving a service retirement allowance, a  
 14 disability retirement allowance or a pension under any other retirement or disability benefit plan  
 15 or system offered by the district or local government for its officers and employees;

16 (ii) Is eligible to receive a service retirement allowance under the Public Employees Retirement  
 17 System and has reached earliest service retirement age under ORS chapter 238;

18 (iii) Is eligible to receive a pension under ORS 238A.100 to 238A.250 and has reached earliest  
 19 retirement age as described in ORS 238A.165; or

20 (iv) Is eligible to receive a service retirement allowance or pension under any other retirement  
 21 benefit plan or system offered by the district or local government and has attained earliest retire-  
 22 ment age under the plan or system.

23 (b) Except as provided in paragraph (a)(B) of this subsection, “eligible employee” does not in-  
 24 clude an individual:

25 (A) Engaged as an independent contractor;

26 (B) Whose periods of employment in emergency work are on an intermittent or irregular basis;  
 27 or

28 (C) Who is employed on less than a half-time basis unless the individual is employed in a posi-  
 29 tion classified as a job-sharing position or unless the individual is defined as eligible under rules of  
 30 the Oregon Educators Benefit Board or under a collective bargaining agreement.

31 (5) “Family member” means an eligible employee’s spouse or domestic partner and any unmar-  
 32 ried child or stepchild of an eligible employee within age limits and other conditions imposed by the  
 33 Oregon Educators Benefit Board with regard to unmarried children or stepchildren.

34 (6) “Local government” means any city, county or special district in this state.

35 (7) “Payroll disbursing officer” means the officer or official authorized to disburse moneys in  
 36 payment of salaries and wages of officers and employees of a district or a local government.

37 (8) “Premium” means the monthly or other periodic charge, including administrative fees of the  
 38 Oregon Educators Benefit Board, for a benefit plan.

39 [(9) “Primary care” means family medicine, general internal medicine, naturopathic medicine,  
 40 obstetrics and gynecology, pediatrics or general psychiatry.]

41 [(10) “Total medical expenditures” means payments to reimburse the cost of physical and mental  
 42 health care provided to eligible employees or their family members, excluding prescription drugs, vision  
 43 care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type  
 44 of payment mechanism.]

45 **SECTION 44.** ORS 243.864 is amended to read:

1 243.864. (1) The Oregon Educators Benefit Board:

2 (a) Shall adopt rules for the conduct of its business [*and for carrying out ORS 243.879*]; and

3 (b) May adopt rules not inconsistent with ORS 243.860 to 243.886 to determine the terms and  
4 conditions of eligible employee participation in and coverage under benefit plans.

5 (2) The board shall study all matters connected with the provision of adequate benefit plan  
6 coverage for eligible employees on the best basis possible with regard to the welfare of the em-  
7 ployees and affordability for the districts and local governments. The board shall design benefits,  
8 prepare specifications, analyze carrier responses to advertisements for bids and award contracts.  
9 Contracts shall be signed by the chairperson on behalf of the board.

10 (3) In carrying out its duties under subsections (1) and (2) of this section, the goal of the board  
11 is to provide high-quality **supplemental** health[, *dental*] and other benefit plans for eligible employ-  
12 ees at a cost affordable to the districts and local governments, the employees and the taxpayers of  
13 Oregon.

14 (4)[(a)] The board shall prepare specifications, invite bids and take actions necessary to award  
15 contracts for **supplemental** health and [*dental*] **other** benefit plan coverage of eligible employees in  
16 accordance with the criteria set forth in ORS 243.866 [(1)] (2).

17 [(b) *Premium rates established by the board for a self-insured health benefit plan and premium*  
18 *rates negotiated by the board with a carrier that offers a health benefit plan to eligible employees must*  
19 *take into account any reduction in the cost of hospital services and supplies anticipated to result from*  
20 *the application of ORS 243.879.*]

21 (c) The Public Contracting Code does not apply to contracts for benefit plans provided under  
22 ORS 243.860 to 243.886. The board may not exclude from competition to contract for a benefit plan  
23 an Oregon carrier solely because the carrier does not serve all counties in Oregon.

24 (5) The board may retain consultants, brokers or other advisory personnel when necessary and  
25 shall employ such personnel as are required to perform the functions of the board. [*If the board*  
26 *contracts for actuarial or technical support to manage the functions of the board, the board shall, no*  
27 *less than every three years, solicit invitations to bid and the proposals must include all of the*  
28 *following:*]

29 [(a) *An explanation of how the bidder has assisted other clients in creating incentives to improve*  
30 *the quality of care provided to enrollees;*]

31 [(b) *An explanation of how the bidder will support the board's efforts to maximize provider effi-*  
32 *ciencies and achieve more organized systems of care; and*]

33 [(c) *A description of the bidder's experience in assisting other clients in structuring contracts that*  
34 *use risk-based networks of providers and alternative provider reimbursement methodologies.*]

35 **SECTION 45.** ORS 243.866 is amended to read:

36 243.866. (1) **Any person who is eligible to enroll in a benefit plan under ORS 243.860 to**  
37 **243.886 shall participate in the Health Care for All Oregon Plan.**

38 [(1)] (2) **If the Oregon Educators Benefit Board contracts for health benefit plans to sup-**  
39 **plement the coverage provided in the Health Care for All Oregon Plan, the board shall con-**  
40 **tract for supplemental health** benefit plans best designed to meet the needs and provide for the  
41 welfare of eligible employees, the districts and local governments. In considering whether to enter  
42 into a contract for a **supplemental health** benefit plan, the board shall place emphasis on:

43 (a) Employee choice among high-quality plans;

44 (b) Encouragement of a competitive marketplace;

45 (c) Plan performance and information;

1 (d) District and local government flexibility in plan design and contracting;

2 (e) Quality customer service;

3 (f) Creativity and innovation;

4 (g) Plan benefits as part of total employee compensation;

5 (h) Improvement of employee health; and

6 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the  
7 **supplemental health benefit** plan.

8 [(2)] (3) The board may approve more than one carrier for each type of **supplemental health**  
9 benefit plan offered, but the board shall limit the number of carriers to a number consistent with  
10 adequate service to eligible employees and family members.

11 [(3)] (4) When appropriate, the board shall provide options under which an eligible employee  
12 may arrange coverage for family members under a **supplemental health** benefit plan.

13 [(4)] (5) A district or a local government shall provide that payroll deductions for **supplemental**  
14 **health** benefit plan costs that are not payable by the district or local government may be made upon  
15 receipt of a signed authorization from the employee indicating an election to participate in the  
16 **supplemental health** benefit plan or plans selected and allowing the deduction of those costs from  
17 the employee's pay.

18 [(5)] (6) In developing any **supplemental health** benefit plan, the board may provide an option  
19 of additional coverage for eligible employees and family members at an additional premium.

20 [(6)] (7) The board shall adopt rules providing that transfer of enrollment from one **supple-**  
21 **mental health** benefit plan to another is open to all eligible employees and family members. [*Be-*  
22 *cause of the special problems that may arise involving acceptable provider-patient relations between a*  
23 *particular panel of providers and a particular eligible employee or family member under a compre-*  
24 *hensive group practice benefit plan, the board shall provide a procedure under which any eligible em-*  
25 *ployee may apply at any time to substitute another benefit plan for participation in a comprehensive*  
26 *group practice benefit plan.*]

27 [(7) *An eligible employee who is retired is not required to participate in a health benefit plan of-*  
28 *fered under this section in order to obtain dental benefit plan coverage. The board shall establish by*  
29 *rule standards of eligibility for retired employees to participate in a dental benefit plan.*]

30 (8) The board shall evaluate a **supplemental health** benefit plan that serves a limited ge-  
31 ographic region of this state according to the criteria described in subsection [(1)] (2) of this section.

32 [(9) *By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures*  
33 *in self-insured health benefit plans on payments for primary care.*]

34 [(10) *No later than February 1 of each year, the board shall report to the Legislative Assembly on*  
35 *the board's progress toward achieving the target of spending at least 12 percent of total medical*  
36 *expenditures on payments for primary care.*]

37 **SECTION 46.** ORS 243.866, as amended by section 28, chapter 746, Oregon Laws 2017, is  
38 amended to read:

39 243.866. (1) **Any person who is eligible to enroll in benefit plan under ORS 243.860 to**  
40 **243.886 shall participate in the Health Care for All Oregon Plan.**

41 [(1)] (2) **If the Oregon Educators Benefit Board contracts for health benefit plans to sup-**  
42 **plement the coverage provided in the Health Care for All Oregon Plan, the board shall con-**  
43 **tract for supplemental health** benefit plans best designed to meet the needs and provide for the  
44 welfare of eligible employees, the districts and local governments. In considering whether to enter  
45 into a contract for a **supplemental health** benefit plan, the board shall place emphasis on:



- 1 (a) Employee choice among high-quality plans;
- 2 (b) Encouragement of a competitive marketplace;
- 3 (c) Plan performance and information;
- 4 (d) District and local government flexibility in plan design and contracting;
- 5 (e) Quality customer service;
- 6 (f) Creativity and innovation;
- 7 (g) Plan benefits as part of total employee compensation;
- 8 (h) Improvement of employee health; and
- 9 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
- 10 **supplemental health benefit** plan.

11 [(2)] (3) The board may approve more than one carrier for each type of **supplemental health**  
 12 benefit plan offered, but the board shall limit the number of carriers to a number consistent with  
 13 adequate service to eligible employees and family members who are not enrolled in another health  
 14 benefit plan offered by the board or the Public Employees' Benefit Board. An eligible employee who  
 15 declines coverage in a **supplemental** health benefit plan offered by the Oregon Educators Benefit  
 16 Board or the Public Employees' Benefit Board and who is enrolled as a spouse or family member in  
 17 another **supplemental** health benefit plan offered by the Oregon Educators Benefit Board or the  
 18 Public Employees' Benefit Board may not be paid the employer contribution for the plan that was  
 19 declined.

20 [(3)] (4) When appropriate, the board shall provide options under which an eligible employee  
 21 may arrange coverage for family members under a **supplemental health** benefit plan.

22 [(4)] (5) A district or a local government shall provide that payroll deductions for **supplemental**  
 23 **health** benefit plan costs that are not payable by the district or local government may be made upon  
 24 receipt of a signed authorization from the employee indicating an election to participate in the  
 25 **supplemental health** benefit plan or plans selected and allowing the deduction of those costs from  
 26 the employee's pay.

27 [(5)] (6) In developing any **supplemental health** benefit plan, the board may provide an option  
 28 of additional coverage for eligible employees and family members at an additional premium.

29 [(6)] (7) The board shall adopt rules providing that transfer of enrollment from one **supple-**  
 30 **mental health** benefit plan to another is open to all eligible employees and family members. [*Be-*  
 31 *cause of the special problems that may arise involving acceptable provider-patient relations between a*  
 32 *particular panel of providers and a particular eligible employee or family member under a compre-*  
 33 *hensive group practice benefit plan, the board shall provide a procedure under which any eligible em-*  
 34 *ployee may apply at any time to substitute another benefit plan for participation in a comprehensive*  
 35 *group practice benefit plan.]*

36 [(7)] *An eligible employee who is retired is not required to participate in a health benefit plan of-*  
 37 *fered under this section in order to obtain dental benefit plan coverage. The board shall establish by*  
 38 *rule standards of eligibility for retired employees to participate in a dental benefit plan.]*

39 (8) The board shall evaluate a **supplemental health** benefit plan that serves a limited ge-  
 40 ographic region of this state according to the criteria described in subsection [(1)] (2) of this section.

41 [(9)(a)] *The board shall use payment methodologies in self-insured health benefit plans offered by*  
 42 *the board that are designed to limit the growth in per-member expenditures for health services to no*  
 43 *more than 3.4 percent per year.]*

44 [(b)] *The board shall adopt policies and practices designed to limit the annual increase in premium*  
 45 *amounts paid for contracted health benefit plans to 3.4 percent.]*

1        [(10) A carrier or third party administrator that contracts with the board to provide or administer  
2 a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan  
3 enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would  
4 affect the cost of the premium for the plan.]

5        [(11) By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures  
6 in self-insured health benefit plans on payments for primary care.]

7        [(12) No later than February 1 of each year, the board shall report to the Legislative Assembly on  
8 the board's progress toward achieving the target of spending at least 12 percent of total medical  
9 expenditures on payments for primary care.]

10        **SECTION 47.** ORS 243.866, as amended by section 17, chapter 489, Oregon Laws 2017, and  
11 section 28, chapter 746, Oregon Laws 2017, is amended to read:

12        243.866. (1) **Any person who is eligible to enroll in a benefit plan under ORS 243.860 to**  
13 **243.886 shall participate in the Health Care for All Oregon Plan.**

14        [(1)] (2) **If the Oregon Educators Benefit Board contracts for health benefit plans to sup-**  
15 **plement the coverage provided in the Health Care for All Oregon Plan, the board** shall con-  
16 tract for **supplemental health** benefit plans best designed to meet the needs and provide for the  
17 welfare of eligible employees, the districts and local governments. In considering whether to enter  
18 into a contract for a **supplemental health** benefit plan, the board shall place emphasis on:

19        (a) Employee choice among high-quality plans;

20        (b) Encouragement of a competitive marketplace;

21        (c) Plan performance and information;

22        (d) District and local government flexibility in plan design and contracting;

23        (e) Quality customer service;

24        (f) Creativity and innovation;

25        (g) Plan benefits as part of total employee compensation;

26        (h) Improvement of employee health; and

27        (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the  
28 **supplemental health benefit** plan.

29        [(2)] (3) The board may approve more than one carrier for each type of **supplemental health**  
30 benefit plan offered, but the board shall limit the number of carriers to a number consistent with  
31 adequate service to eligible employees and family members who are not enrolled in another health  
32 benefit plan offered by the board or the Public Employees' Benefit Board. An eligible employee who  
33 declines coverage in a **supplemental** health benefit plan offered by the Oregon Educators Benefit  
34 Board or the Public Employees' Benefit Board and who is enrolled as a spouse or family member in  
35 another **supplemental** health benefit plan offered by the Oregon Educators Benefit Board or the  
36 Public Employees' Benefit Board may not be paid the employer contribution for the plan that was  
37 declined.

38        [(3)] (4) When appropriate, the board shall provide options under which an eligible employee  
39 may arrange coverage for family members under a **supplemental health** benefit plan.

40        [(4)] (5) A district or a local government shall provide that payroll deductions for **supplemental**  
41 **health** benefit plan costs that are not payable by the district or local government may be made upon  
42 receipt of a signed authorization from the employee indicating an election to participate in the  
43 **supplemental health** benefit plan or plans selected and allowing the deduction of those costs from  
44 the employee's pay.

45        [(5)] (6) In developing any **supplemental health** benefit plan, the board may provide an option

1 of additional coverage for eligible employees and family members at an additional premium.

2 [(6)] (7) The board shall adopt rules providing that transfer of enrollment from one **supple-**  
 3 **mental health** benefit plan to another is open to all eligible employees and family members. [*Be-*  
 4 *cause of the special problems that may arise involving acceptable provider-patient relations between a*  
 5 *particular panel of providers and a particular eligible employee or family member under a compre-*  
 6 *hensive group practice benefit plan, the board shall provide a procedure under which any eligible em-*  
 7 *ployee may apply at any time to substitute another benefit plan for participation in a comprehensive*  
 8 *group practice benefit plan.*]

9 [(7) *An eligible employee who is retired is not required to participate in a health benefit plan of-*  
 10 *fered under this section in order to obtain dental benefit plan coverage. The board shall establish by*  
 11 *rule standards of eligibility for retired employees to participate in a dental benefit plan.*]

12 (8) The board shall evaluate a **supplemental health** benefit plan that serves a limited ge-  
 13 ographic region of this state according to the criteria described in subsection [(1)] (2) of this section.

14 [(9)(a) *The board shall use payment methodologies in self-insured health benefit plans offered by*  
 15 *the board that are designed to limit the growth in per-member expenditures for health services to no*  
 16 *more than 3.4 percent per year.*]

17 [(b) *The board shall adopt policies and practices designed to limit the annual increase in premium*  
 18 *amounts paid for contracted health benefit plans to 3.4 percent.*]

19 [(10) *A carrier or third party administrator that contracts with the board to provide or administer*  
 20 *a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan*  
 21 *enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would*  
 22 *affect the cost of the premium for the plan.*]

23 [(11) *If the board spends less than 12 percent of its total medical expenditures in self-insured health*  
 24 *benefit plans on payments for primary care, the board shall implement a plan for increasing the per-*  
 25 *centage of total medical expenditures spent on payments for primary care by at least one percent each*  
 26 *year.*]

27 [(12) *No later than February 1 of each year, the board shall report to the Legislative Assembly on*  
 28 *any plan implemented under subsection (11) of this section and on the board's progress toward*  
 29 *achieving the target of spending at least 12 percent of total medical expenditures on payments for pri-*  
 30 *mary care.*]

31 **SECTION 48.** ORS 243.867 is amended to read:

32 243.867. (1) The governing body of a local government may elect to participate in a benefit plan  
 33 offered by the Oregon Educators Benefit Board.

34 (2) The decision of the governing body of a local government to participate in a benefit plan  
 35 offered by the board is in the discretion of the governing body of the local government and is a  
 36 permissive subject of collective bargaining.

37 [(3) *If the governing body of a local government elects to offer a benefit plan through the board,*  
 38 *the governing body may elect one time only to provide alternative group health and welfare insurance*  
 39 *benefit plans to eligible employees if:*]

40 [(a) *The alternative benefit plan is offered through the health insurance exchange under ORS*  
 41 *741.310 (1)(b); and]*

42 [(b) *The participation of the local government is not precluded under federal law on or after Jan-*  
 43 *uary 1, 2017.*]

44 **SECTION 49.** ORS 243.868 is amended to read:

45 243.868. (1) [*In addition to contracting for health and dental benefit plans,*] The Oregon Educators

1 Benefit Board may contract with carriers to provide [*other*] benefit plans including, but not limited  
 2 to, insurance or other benefits based on life, supplemental medical, supplemental dental, supple-  
 3 mental vision, accidental death or disability insurance plans.

4 (2) The premium for each eligible employee for coverage under a benefit plan [*other than a*  
 5 *health or dental benefit plan*] described in subsection (1) of this section shall be the total cost per  
 6 month of the coverage afforded the employee under the plan for which the employee exercises an  
 7 option, including the cost of enrollment and administrative expenses for the plan.

8 (3) The board may withdraw approval of any additional benefit plan in the same manner as [*it*]  
 9 **the board** withdraws approval [*of a health or dental benefit plan as described and authorized by*]  
 10 **under** ORS 243.878.

11 (4) If the board does not contract for a benefit plan described in subsection (1) of this section,  
 12 a district or a local government may contract for the benefit plan on behalf of any district or local  
 13 government employees. The administrative expenses of the **benefit** plan shall be paid in accordance  
 14 with the negotiated agreement between the employees and the district or local government. Benefit  
 15 plans entered into by a district or local government are subject to approval by the board before  
 16 [*they*] **the contracts** become operative. The board may withdraw approval of any such benefit plan  
 17 in the same manner as [*it*] **the board** withdraws approval [*of a benefit plan*] under ORS 243.878.

18 **SECTION 50.** ORS 243.874 is amended to read:

19 243.874. (1) In addition to the powers and duties otherwise provided by law to provide benefit  
 20 plans for eligible employees, the Oregon Educators Benefit Board may provide and administer flex-  
 21 ible benefit plans under which eligible employees may choose among taxable and nontaxable benefits  
 22 as provided in the federal Internal Revenue Code.

23 (2) In providing flexible benefit plans, the board may offer:

24 (a) **Supplemental** health or dental benefits as described in ORS 243.864 and 243.866.

25 (b) [*Other insurance benefits as*] **Benefit plans** described in ORS 243.868.

26 (c) Any other benefit that may be excluded from an employee's gross income under the federal  
 27 Internal Revenue Code.

28 (d) Any part or all of the district or local government contribution for employee benefits in cash  
 29 to the employee.

30 (3) In developing flexible benefit plans, the board shall design the plans on the best basis pos-  
 31 sible with regard to the welfare of the employees and affordability for the districts and local gov-  
 32 ernments.

33 (4) The board may pay some or all of the cost of administering flexible benefit plans from funds  
 34 authorized to pay general administrative expenses incurred by the board.

35 (5) The board shall adopt rules as the board considers necessary for the establishment and ad-  
 36 ministration of flexible benefit plans.

37 (6) The board may contract with private organizations for administration of flexible benefit plans  
 38 in accordance with rules adopted under subsection (5) of this section.

39 **SECTION 51.** ORS 243.886 is amended to read:

40 243.886. (1) Except as provided in subsections (2), (3) and (4) of this section, a district may not  
 41 provide or contract for a benefit plan and eligible employees of districts may not participate in a  
 42 benefit plan unless the benefit plan:

43 (a) Is provided and administered by the Oregon Educators Benefit Board under ORS 243.860 to  
 44 243.886; or

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

**(b) Is the Health Care for All Oregon Plan.**

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

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

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

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

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

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

(4) Nothing in ORS 243.860 to 243.886 may be construed to expand or contract collective bargaining rights or collective bargaining obligations.

**SECTION 52.** ORS 731.036 is amended to read:

731.036. Except as provided in ORS 743.029 or as specifically provided by law, the Insurance Code does not apply to any of the following to the extent of the subject matter of the exemption:

(1) A bail bondsman, other than a corporate surety and its agents.

(2) A fraternal benefit society that has maintained lodges in this state and other states for 50 years prior to January 1, 1961, and for which a certificate of authority was not required on that date.

(3) A religious organization providing insurance benefits only to its employees, if the organization is in existence and exempt from taxation under section 501(c)(3) of the federal Internal Revenue Code on September 13, 1975.

(4) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for tort liability in accordance with ORS 30.282.

(5) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for property damage in accordance with ORS 30.282.

(6) Cities, counties, school districts, community college districts, community college service districts or districts, as defined in ORS 198.010 and 198.180, that either individually or jointly *insure*

1 for] **self-insure a supplemental** health insurance coverage **program**, excluding disability insurance,  
2 their employees or retired employees, or their dependents, or students engaged in school activities,  
3 or combination of employees and dependents, with or without employee or student contributions, if  
4 all of the following conditions are met:

5 (a) The [*individual or jointly self-insured*] program meets the following minimum requirements:

6 (A) In the case of a school district, community college district or community college service  
7 district, the number of covered employees and dependents and retired employees and dependents  
8 aggregates at least 500 individuals;

9 (B) In the case of an individual public body program other than a school district, community  
10 college district or community college service district, the number of covered employees and depen-  
11 dents and retired employees and dependents aggregates at least 500 individuals; and

12 (C) In the case of a joint program of two or more public bodies, the number of covered em-  
13 ployees and dependents and retired employees and dependents aggregates at least 1,000 individuals;

14 (b) The [*individual or jointly self-insured health insurance*] program includes all coverages and  
15 benefits required of group health insurance policies under ORS chapters 743, 743A and 743B;

16 (c) The [*individual or jointly self-insured*] program must have program documents that define  
17 program benefits and administration;

18 (d) Enrollees must be provided copies of summary plan descriptions including:

19 (A) Written general information about services provided, access to services, charges and sched-  
20 uling applicable to each enrollee's coverage;

21 (B) The program's grievance and appeal process; and

22 (C) Other group health plan enrollee rights, disclosure or written procedure requirements es-  
23 tablished under ORS chapters 743, 743A and 743B;

24 (e) The financial administration of [*an individual or jointly self-insured*] **the** program must in-  
25 clude the following requirements:

26 (A) Program contributions and reserves must be held in separate accounts and used for the ex-  
27 clusive benefit of the program;

28 (B) The program must maintain adequate reserves. Reserves may be invested in accordance with  
29 the provisions of ORS chapter 293. Reserve adequacy must be calculated annually with proper  
30 actuarial calculations including the following:

31 (i) Known claims, paid and outstanding;

32 (ii) A history of incurred but not reported claims;

33 (iii) Claims handling expenses;

34 (iv) Unearned contributions; and

35 (v) A claims trend factor; and

36 (C) The program must maintain adequate reinsurance against the risk of economic loss in ac-  
37 cordance with the provisions of ORS 742.065 unless the program has received written approval for  
38 an alternative arrangement for protection against economic loss from the Director of the Depart-  
39 ment of Consumer and Business Services;

40 (f) The [*individual or jointly self-insured*] program must have sufficient personnel to service the  
41 employee benefit program or must contract with a third party administrator licensed under ORS  
42 chapter 744 as a third party administrator to provide such services;

43 (g) The public body, or the program administrator in the case of a joint [*insurance*] program of  
44 two or more public bodies, files with the Director of the Department of Consumer and Business  
45 Services copies of all documents creating and governing the program, all forms used to communicate

1 the coverage to beneficiaries, the schedule of payments established to support the program and,  
2 annually, a financial report showing the total incurred cost of the program for the preceding year.  
3 A copy of the annual audit required by ORS 297.425 may be used to satisfy the financial report filing  
4 requirement; and

5 (h) Each public body in a joint [*insurance*] program is liable only to its own employees and no  
6 others for benefits under the program in the event, and to the extent, that no further funds, in-  
7 cluding funds from insurance policies obtained by the pool, are available in the joint insurance pool.

8 (7) All ambulance services.

9 (8) A person providing any of the services described in this subsection. The exemption under this  
10 subsection does not apply to an authorized insurer providing such services under an insurance pol-  
11 icy. This subsection applies to the following services:

12 (a) Towing service.

13 (b) Emergency road service, which means adjustment, repair or replacement of the equipment,  
14 tires or mechanical parts of a motor vehicle in order to permit the motor vehicle to be operated  
15 under its own power.

16 (c) Transportation and arrangements for the transportation of human remains, including all  
17 necessary and appropriate preparations for and actual transportation provided to return a  
18 decedent's remains from the decedent's place of death to a location designated by a person with  
19 valid legal authority under ORS 97.130.

20 (9)(a) A person described in this subsection who, in an agreement to lease or to finance the  
21 purchase of a motor vehicle, agrees to waive for no additional charge the amount specified in par-  
22 agraph (b) of this subsection upon total loss of the motor vehicle because of physical damage, theft  
23 or other occurrence, as specified in the agreement. The exemption established in this subsection  
24 applies to the following persons:

25 (A) The seller of the motor vehicle, if the sale is made pursuant to a motor vehicle retail in-  
26 stallment contract.

27 (B) The lessor of the motor vehicle.

28 (C) The lender who finances the purchase of the motor vehicle.

29 (D) The assignee of a person described in this paragraph.

30 (b) The amount waived pursuant to the agreement shall be the difference, or portion thereof,  
31 between the amount received by the seller, lessor, lender or assignee, as applicable, that represents  
32 the actual cash value of the motor vehicle at the date of loss, and the amount owed under the  
33 agreement.

34 (10) A self-insurance program for tort liability or property damage that is established by two or  
35 more affordable housing entities and that complies with the same requirements that public bodies  
36 must meet under ORS 30.282 (6). As used in this subsection:

37 (a) "Affordable housing" means housing projects in which some of the dwelling units may be  
38 purchased or rented, with or without government assistance, on a basis that is affordable to indi-  
39 viduals of low income.

40 (b) "Affordable housing entity" means any of the following:

41 (A) A housing authority created under the laws of this state or another jurisdiction and any  
42 agency or instrumentality of a housing authority, including but not limited to a legal entity created  
43 to conduct a self-insurance program for housing authorities that complies with ORS 30.282 (6).

44 (B) A nonprofit corporation that is engaged in providing affordable housing.

45 (C) A partnership or limited liability company that is engaged in providing affordable housing

1 and that is affiliated with a housing authority described in subparagraph (A) of this paragraph or  
 2 a nonprofit corporation described in subparagraph (B) of this paragraph if the housing authority or  
 3 nonprofit corporation:

4 (i) Has, or has the right to acquire, a financial or ownership interest in the partnership or lim-  
 5 ited liability company;

6 (ii) Has the power to direct the management or policies of the partnership or limited liability  
 7 company;

8 (iii) Has entered into a contract to lease, manage or operate the affordable housing owned by  
 9 the partnership or limited liability company; or

10 (iv) Has any other material relationship with the partnership or limited liability company.

11 (11) Except as provided in ORS 735.500 and 735.510, a person certified by the Department of  
 12 Consumer and Business Services to operate a retainer medical practice.

### 13 14 CONFORMING AMENDMENTS

15  
16 **SECTION 53.** ORS 346.565 is amended to read:

17 346.565. (1) A business enterprise manager who is blind, as described under ORS 346.510 to  
 18 346.570, or a person who is blind who is an employee of a private nonprofit Oregon corporation es-  
 19 tablished and authorized by the Commission for the Blind to provide employment to persons who are  
 20 blind may participate in a **supplemental** health benefit plan available to state employees pursuant  
 21 to ORS 243.105 to 243.285 at the expense of the manager or employee.

22 (2) A business enterprise manager who is blind, as described under ORS 346.510 to 346.570, may  
 23 participate in state deferred compensation plan established under ORS 243.401 to 243.507, contingent  
 24 on participation not affecting the tax exempt status of other contributions to the deferred compen-  
 25 sation plan.

26 (3) For the purposes of subsections (1) and (2) of this section, such managers and employees shall  
 27 be considered eligible state employees.

28 **SECTION 54.** ORS 352.237 is amended to read:

29 352.237. (1) The governing board of each public university listed in ORS 352.002 shall provide  
 30 group insurance to employees of the university through the Public Employees' Benefit Board [*or may*  
 31 *elect to provide an alternative group health and welfare insurance benefit plan to employees of the*  
 32 *university on or after October 1, 2016, if the benefit plan is offered through the health insurance ex-*  
 33 *change under ORS 741.310, unless their participation is precluded by federal law].*

34 (2) For the purposes of ORS 243.555 to 243.575, if the governing board of a public university  
 35 listed in ORS 352.002 chooses not to participate in the benefit plans offered through the Public  
 36 Employees' Benefit Board, the governing board may have the authority granted to the Public  
 37 Employees' Benefit Board under ORS 243.555 to 243.575 for the administration of an appropriate  
 38 expense reimbursement plan.

39 (3) The governing board of each public university listed in ORS 352.002 shall offer one or more  
 40 deferred compensation plans to employees of the university. The governing board shall choose  
 41 whether to offer its employees the state deferred compensation plan established under ORS 243.401  
 42 to 243.507 or another deferred compensation plan that the governing board elects to make available  
 43 to the employees of the university.

44 **SECTION 55.** ORS 408.370 is amended to read:

45 408.370. (1) In addition to the other uses for the Oregon Housing Fund set forth in ORS 458.600



1 to 458.665, financial support for an Oregon Veterans' Home is a permitted use of moneys from the  
2 Oregon Housing Fund.

3 (2) *[Notwithstanding ORS 442.315 and 442.325,]* An Oregon Veterans' Home is not subject to any  
4 certificate of need requirement **under ORS 442.315 or any requirement of a Regional Planning**  
5 **Board under section 16 of this 2019 Act.**

6 **SECTION 56.** ORS 408.380 is amended to read:

7 408.380. (1) The Oregon Veterans' Home authorized by section 1, chapter 591, Oregon Laws 1995,  
8 is subject to all state laws and administrative rules and all federal laws and administrative regu-  
9 lations to which long term care facilities operated by nongovernmental entities are subject, except  
10 for the requirement to obtain a certificate of need under ORS 442.315 *[from the Oregon Health Au-*  
11 *thority]*.

12 (2) As used in this section, "long term care facility" has the meaning given that term in ORS  
13 442.015.

14 **SECTION 57.** ORS 411.400 is amended to read:

15 411.400. (1) An application for any category of aid shall also constitute an application for med-  
16 ical assistance.

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

- 22 (a) Over the Internet;
- 23 (b) By telephone;
- 24 (c) By mail;
- 25 (d) In person; and
- 26 (e) Through other commonly available electronic means.

27 (3) The department and the authority may require an applicant or person acting on behalf of  
28 an applicant to provide only the information necessary for the purpose of making an eligibility de-  
29 termination or for a purpose directly connected to the administration of medical assistance *[or the*  
30 *health insurance exchange]*.

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

- 35 (a) Over the Internet;
- 36 (b) By telephone; and
- 37 (c) In person.

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

43 *[(b)]* (5) The department *[of Human Services]* shall promptly transfer information received under  
44 this section to the authority for individuals who are eligible for medical assistance *[because they*  
45 *qualify for public assistance]* **or for the Health Care for All Oregon Plan.**

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

6        **SECTION 58.** ORS 411.402 is amended to read:

7        411.402. (1) The Department of Human Services and the Oregon Health Authority shall adopt  
 8 by rule, consistent with federal requirements, the procedures for verifying eligibility for medical  
 9 assistance, including but not limited to all of the following:

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

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

13        (A) Pregnancy;

14        (B) Date of birth;

15        (C) Household composition; and

16        (D) Residency.

17        (c) The department and the authority may not use self-attestation to verify citizenship and im-  
 18 migration status.

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

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

26        (2) Information obtained by the department or the authority under this section may be ex-  
 27 changed [*with the health insurance exchange and*] with other state or federal agencies for the pur-  
 28 pose of:

29        (a) Verifying eligibility for medical assistance[, *participation in the exchange*] or other health  
 30 benefit programs;

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

33        [(c)] (b) Improving the provision of services; and

34        [(d)] (c) Administering health benefit programs.

35        **SECTION 59.** ORS 411.406 is amended to read:

36        411.406. (1) A medical assistance recipient shall immediately notify the Department of Human  
 37 Services or the Oregon Health Authority, if required, of the receipt or possession of property or  
 38 income or other change in circumstances that directly affects the eligibility of the recipient to re-  
 39 ceive medical assistance, or that directly affects the amount of medical assistance for which the  
 40 recipient is eligible. Failure to give the notice shall entitle the department or the authority to re-  
 41 cover from the recipient the amount of assistance improperly disbursed by reason thereof.

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

44        (b) The department and the authority shall redetermine eligibility under this subsection on the  
 45 basis of information available to the department and the authority and may not require the recipient

1 to provide information if the department or the authority is able to determine eligibility based on  
 2 information in the recipient's record or through other information that is available to the depart-  
 3 ment or the authority.

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

7 (4) If the department or the authority determines that a medical assistance recipient no longer  
 8 qualifies for the medical assistance program in which the recipient is enrolled, the department or  
 9 the authority must determine eligibility for other medical assistance programs[,] **and** potential eli-  
 10 gibility for the [*health insurance exchange, premium tax credits and cost-sharing reductions*] **Health**  
 11 **Care for All Oregon Plan** before terminating the recipient's medical assistance. [*If the recipient*  
 12 *appears to qualify for the exchange, premium tax credits or cost-sharing reductions, the department or*  
 13 *the authority shall promptly transfer the recipient's record to the exchange to process those benefits.*]

14 **SECTION 60.** ORS 413.011 is amended to read:

15 413.011. (1) The duties of the Oregon Health Policy Board are to:

16 (a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS  
 17 413.032 and all of the authority's departmental divisions.

18 [*(b) Develop and submit a plan to the Legislative Assembly by December 31, 2010, to provide and*  
 19 *fund access to affordable, quality health care for all Oregonians by 2015.*]

20 [*(c) Develop a program to provide health insurance premium assistance to all low and moderate*  
 21 *income individuals who are legal residents of Oregon.*]

22 [(d)] (b) Publish health outcome and quality measure data collected by the Oregon Health Au-  
 23 thority at aggregate levels that do not disclose information otherwise protected by law. The infor-  
 24 mation published must report, for each coordinated care organization and each **supplemental** health  
 25 benefit plan [*sold through the health insurance exchange or*] offered by the Oregon Educators Benefit  
 26 Board or the Public Employees' Benefit Board:

27 (A) Quality measures;

28 (B) Costs;

29 (C) Health outcomes; and

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

33 [(e)] (c) Establish evidence-based clinical standards and practice guidelines that may be used by  
 34 providers.

35 [(f)] (d) Approve and monitor community-centered health initiatives described in ORS 413.032  
 36 (1)(h) that are consistent with public health goals, strategies, programs and performance standards  
 37 adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and shall reg-  
 38 ularly report to the Legislative Assembly on the accomplishments and needed changes to the initi-  
 39 atives.

40 [(g)] (e) Establish [*cost containment*] **cost-containment** mechanisms to reduce health care costs.

41 [(h)] (f) Ensure that Oregon's health care workforce is sufficient in numbers and training to  
 42 meet the demand that will be created by the expansion in health coverage, health care system  
 43 transformations, an increasingly diverse population and an aging workforce.

44 [(i)] (g) Work with the Oregon congressional delegation to advance the adoption of changes in  
 45 federal law or policy to promote Oregon's comprehensive health reform plan.

1        *[(j) Establish a health benefit package in accordance with ORS 741.340 to be used as the baseline*  
2 *for all health benefit plans offered through the health insurance exchange.]*

3        *[(k) Investigate and report annually to the Legislative Assembly on the feasibility and advisability*  
4 *of future changes to the health insurance market in Oregon, including but not limited to the*  
5 *following:]*

6            *[(A) A requirement for every resident to have health insurance coverage.]*

7            *[(B) A payroll tax as a means to encourage employers to continue providing health insurance to*  
8 *their employees.]*

9        *[(L)] (h) Meet cost-containment goals by structuring reimbursement rates to reward compre-*  
10 *hensive management of diseases, quality outcomes and the efficient use of resources by promoting*  
11 *cost-effective procedures, services and programs including, without limitation, preventive health,*  
12 *dental and primary care services, web-based office visits, telephone consultations and telemedicine*  
13 *consultations.*

14        *[(m)] (i) Oversee the expenditure of moneys from the Health Care Workforce Strategic Fund to*  
15 *support grants to primary care providers and rural health practitioners, to increase the number of*  
16 *primary care educators and to support efforts to create and develop career ladder opportunities.*

17        *[(n)] (j) Work with the Public Health Benefit Purchasers Committee, administrators of the med-*  
18 *ical assistance program and the Department of Corrections to identify uniform contracting standards*  
19 *for health benefit plans that achieve maximum quality and cost outcomes and align the contracting*  
20 *standards for all state programs to the greatest extent practicable.*

21        *[(o)] (k) Work with the Health Information Technology Oversight Council to foster health in-*  
22 *formation technology systems and practices that promote the Oregon Integrated and Coordinated*  
23 *Health Care Delivery System established by ORS 414.620 and align health information technology*  
24 *systems and practices across this state.*

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

26        (a) Subject to the approval of the Governor **and the Health Care for All Oregon Board es-**  
27 **ta** **bl** **is** **h** **e** **d** **u** **n** **d** **e** **r** **s** **e** **c** **t** **i** **o** **n**  **t** **h** **e**  **O** **r** **e** **g** **a** **n** **i** **z** **e** **d**  **t** **h** **e**  **O** **r** **e** **g** **o** **n**  **H** **e** **a** **l** **t** **h**  **A** **u** **t** **h** **o** **r** **i** **t** **y**  
28 **a** **s**  **t** **h** **e**  **O** **r** **e** **g** **o** **n**  **H** **e** **a** **l** **t** **h**  **P** **o** **l** **i** **c** **y** **B** **o** **a** **r** **d**  **c** **o** **n** **s** **i** **d** **e** **r** **s**  **n** **e** **c** **e** **s** **s** **a** **r** **y**  **t** **o**  **p** **r** **o** **p** **e** **r** **l** **y**  **c** **o** **n** **d** **u** **c** **t**  **t** **h** **e**  **a** **u** **t** **h** **o** **r** **i** **t** **y**.  
29

30        (b) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered  
31 year, requests for measures necessary to provide statutory authorization to carry out any of the  
32 board's duties or to implement any of the board's recommendations. The measures may be filed prior  
33 to the beginning of the legislative session in accordance with the rules of the House of Represen-  
34 tatives and the Senate.

35        (3) If the board or the authority is unable to perform, in whole or in part, any of the duties  
36 described in ORS 413.006 to 413.042 *[and 741.340]* without federal approval, the authority is author-  
37 ized to request, in accordance with ORS 413.072, waivers or other approval necessary to perform  
38 those duties. The authority shall implement any portions of those duties not requiring legislative  
39 authority or federal approval, to the extent practicable.

40        (4) The enumeration of duties, functions and powers in this section is not intended to be exclu-  
41 sive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042  
42 *[and 741.340]* and by other statutes.

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

45        **SECTION 61.** ORS 413.017 is amended to read:

1 413.017. (1) The Oregon Health Policy Board shall establish the committees described in sub-  
2 sections (2) to (4) of this section.

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

5 (A) The Public Employees' Benefit Board.

6 (B) The Oregon Educators Benefit Board.

7 (C) Trustees of the Public Employees Retirement System.

8 (D) A city government.

9 (E) A county government.

10 (F) A special district.

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

13 (b) The Public Health Benefit Purchasers Committee shall:

14 (A) Identify and make specific recommendations to achieve uniformity across all public health  
15 benefit plan designs based on the best available clinical evidence, recognized best practices for  
16 health promotion and disease management, demonstrated cost-effectiveness and shared demographics  
17 among the enrollees within the pools covered by the benefit plans.

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

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

24 [*(c) The Oregon Health Policy Board shall work with the Public Health Benefit Purchasers Com-*  
25 *mittee to identify uniform provisions for state and local public contracts for health benefit plans that*  
26 *achieve maximum quality and cost outcomes. The board shall collaborate with the committee to develop*  
27 *steps to implement joint contract provisions. The committee shall identify a schedule for the implemen-*  
28 *tation of contract changes. The process for implementation of joint contract provisions must include a*  
29 *review process to protect against unintended cost shifts to enrollees or agencies.*]

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

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

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

39 (4)(a) The Health Plan Quality Metrics Committee shall include the following members appointed  
40 by the Governor:

41 (A) An individual representing the Oregon Health Authority;

42 (B) An individual representing the Oregon Educators Benefit Board;

43 (C) An individual representing the Public Employees' Benefit Board;

44 (D) An individual representing the Department of Consumer and Business Services;

45 (E) Two health care providers;

- 1 (F) One individual representing hospitals;
- 2 (G) One individual representing insurers, large employers or multiple employer welfare ar-
- 3 rangements;
- 4 (H) Two individuals representing health care consumers;
- 5 (I) Two individuals representing coordinated care organizations;
- 6 (J) One individual with expertise in health care research;
- 7 (K) One individual with expertise in health care quality measures; and
- 8 (L) One individual with expertise in mental health and addiction services.
- 9 (b) The committee shall work collaboratively with the Oregon Educators Benefit Board, the
- 10 Public Employees' Benefit Board, the Oregon Health Authority and the Department of Consumer and
- 11 Business Services to adopt health outcome and quality measures that are focused on specific goals
- 12 and provide value to the state, employers, insurers, health care providers and consumers. The com-
- 13 mittee shall be the single body to align health outcome and quality measures used in this state with
- 14 the requirements of health care data reporting to ensure that the measures and requirements are
- 15 coordinated, evidence-based and focused on a long term statewide vision.
- 16 (c) The committee shall use a public process that includes an opportunity for public comment
- 17 to identify health outcome and quality measures that may be applied to services provided by coor-
- 18 dinated care organizations or **the Health Care for All Oregon Plan**. *[paid for by health benefit*
- 19 *plans sold through the health insurance exchange or offered by the Oregon Educators Benefit Board*
- 20 *or the Public Employees' Benefit Board. The Oregon Health Authority, the Department of Consumer*
- 21 *and Business Services, the Oregon Educators Benefit Board and the Public Employees' Benefit Board*
- 22 *are]* **The Health Care for All Oregon Board** is not required to adopt all of the health outcome and
- 23 quality measures identified by the committee but may not adopt any health outcome and quality
- 24 measures that are different from the measures identified by the committee. The measures must take
- 25 into account the recommendations of the metrics and scoring subcommittee created in ORS 414.638
- 26 and the differences in the populations served by coordinated care organizations and by commercial
- 27 insurers.
- 28 (d) In identifying health outcome and quality measures, the committee shall prioritize measures
- 29 that:
- 30 (A) Utilize existing state and national health outcome and quality measures, including measures
- 31 adopted by the Centers for Medicare and Medicaid Services, that have been adopted or endorsed
- 32 by other state or national organizations and have a relevant state or national benchmark;
- 33 (B) Given the context in which each measure is applied, are not prone to random variations
- 34 based on the size of the denominator;
- 35 (C) Utilize existing data systems, to the extent practicable, for reporting the measures to mini-
- 36 mize redundant reporting and undue burden on the state, health benefit plans and health care pro-
- 37 viders;
- 38 (D) Can be meaningfully adopted for a minimum of three years;
- 39 (E) Use a common format in the collection of the data and facilitate the public reporting of the
- 40 data; and
- 41 (F) Can be reported in a timely manner and without significant delay so that the most current
- 42 and actionable data is available.
- 43 (e) The committee shall evaluate on a regular and ongoing basis the health outcome and quality
- 44 measures adopted under this section.
- 45 (f) The committee may convene subcommittees to focus on gaining expertise in particular areas

1 such as data collection, health care research and mental health and substance use disorders in order  
 2 to aid the committee in the development of health outcome and quality measures. A subcommittee  
 3 may include stakeholders and staff from the Oregon Health Authority, the Department of Human  
 4 Services, [*the Department of Consumer and Business Services,*] the Early Learning Council or any  
 5 other agency staff with the appropriate expertise in the issues addressed by the subcommittee.

6 (g) This subsection does not prevent the Oregon Health Authority[, *the Department of Consumer*  
 7 *and Business Services, commercial insurers, the Public Employees' Benefit Board or the Oregon Edu-*  
 8 *cators Benefit Board*] **or the Health Care for All Oregon Board** from establishing programs that  
 9 provide financial incentives to providers for meeting specific health outcome and quality measures  
 10 adopted by the committee.

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

16 **SECTION 62.** ORS 413.032 is amended to read:

17 413.032. (1) The Oregon Health Authority is established. The authority shall:

18 (a) Carry out policies adopted by the Oregon Health Policy Board **and the Health Care for**  
 19 **All Oregon Board**;

20 (b) Administer the Oregon Integrated and Coordinated Health Care Delivery System established  
 21 in ORS 414.620;

22 (c) Administer the Oregon Prescription Drug Program;

23 (d) Develop the policies for and the provision of publicly funded medical care and medical as-  
 24 sistance in this state;

25 (e) Develop the policies for and the provision of mental health treatment and treatment of ad-  
 26 dictions;

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

28 (g) Provide regular reports to the **Oregon Health Policy** Board with respect to the performance  
 29 of health services contractors serving recipients of medical assistance, including reports of trends  
 30 in health services and enrollee satisfaction;

31 (h) Guide and support, with the authorization of the **Oregon Health Policy** Board, community-  
 32 centered health initiatives designed to address critical risk factors, especially those that contribute  
 33 to chronic disease;

34 (i) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the  
 35 Social Security Act and administer medical assistance under ORS chapter 414;

36 (j) In consultation with the Director of the Department of Consumer and Business Services, pe-  
 37 riodically review and recommend standards and methodologies to the Legislative Assembly for:

38 (A) Review of administrative expenses of health insurers;

39 (B) Approval of rates; and

40 (C) Enforcement of rating rules adopted by the Department of Consumer and Business Services;

41 (k) Structure reimbursement rates for providers that serve recipients of medical assistance to  
 42 reward comprehensive management of diseases, quality outcomes and the efficient use of resources  
 43 and to promote cost-effective procedures, services and programs including, without limitation, pre-  
 44 ventive health, dental and primary care services, web-based office visits, telephone consultations and  
 45 telemedicine consultations;

1 (L) Guide and support community three-share agreements in which an employer, state or local  
 2 government and an individual all contribute a portion of a premium for a community-centered health  
 3 initiative or for insurance coverage;

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

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

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

11 (2) The Oregon Health Authority is authorized to:

12 (a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate  
 13 health care reform in Oregon and to provide comparative cost and quality information to consumers,  
 14 providers and purchasers of health care about Oregon's health care systems and health plan net-  
 15 works in order to provide comparative information to consumers.

16 (b) Develop uniform contracting standards for the purchase of health care, including the fol-  
 17 lowing:

18 (A) Uniform quality standards and performance measures;

19 (B) Evidence-based guidelines for major chronic disease management and health care services  
 20 with unexplained variations in frequency or cost;

21 (C) Evidence-based effectiveness guidelines for select new technologies and medical equipment;  
 22 and

23 (D) A statewide drug formulary that may be used by publicly funded health benefit plans.

24 (3) The enumeration of duties, functions and powers in this section is not intended to be exclu-  
 25 sive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Au-  
 26 thority by ORS 413.006 to 413.042 and [741.340] **section 11 of this 2019 Act** or by other statutes.

27 **SECTION 63.** ORS 413.037 is amended to read:

28 413.037. (1) The Director of the Oregon Health Authority, each deputy director and authorized  
 29 representatives of the director may administer oaths, take depositions and issue subpoenas to compel  
 30 the attendance of witnesses and the production of documents or other written information necessary  
 31 to carry out the provisions of ORS 413.006 to 413.042 and [741.340] **section 11 of this 2019 Act**.

32 (2) If any person fails to comply with a subpoena issued under this section or refuses to testify  
 33 on matters on which the person lawfully may be interrogated, the director, deputy director or au-  
 34 thorized representative may follow the procedure set out in ORS 183.440 to compel obedience.

35 **SECTION 64.** ORS 414.025 is amended to read:

36 414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially  
 37 applicable statutory definition requires otherwise:

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

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

42 (A) Shared savings arrangements;

43 (B) Bundled payments; and

44 (C) Payments based on episodes.

45 (2) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in



1 person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

2 (3) "Behavioral health clinician" means:

3 (a) A licensed psychiatrist;

4 (b) A licensed psychologist;

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

6 (d) A licensed clinical social worker;

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

8 (f) A certified clinical social work associate;

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

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

13 (4) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability  
14 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-  
15 partment or admission to a hospital to prevent a serious deterioration in the individual's mental or  
16 physical health.

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

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

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

26 (a) Has expertise or experience in public health;

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

29 (c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experi-  
30 ences with the residents of the community where the worker serves;

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

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

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

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

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

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

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

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

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

45 (10)(a) "Family support specialist" means an individual who meets qualification criteria adopted

1 by the authority under ORS 414.665 and who provides supportive services to and has experience  
2 parenting a child who:

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

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

6 (b) A “family support specialist” may be a peer wellness specialist or a peer support specialist.

7 (11) “Global budget” means a total amount established prospectively by the Oregon Health Au-  
8 thority to be paid to a coordinated care organization for the delivery of, management of, access to  
9 and quality of the health care delivered to members of the coordinated care organization.

10 [(12) “Health insurance exchange” or “exchange” means an American Health Benefit Exchange  
11 described in 42 U.S.C. 18031, 18032, 18033 and 18041.]

12 [(13)] (12) “Health services” means at least so much of each of the following as are funded by  
13 the Legislative Assembly based upon the prioritized list of health services compiled by the Health  
14 Evidence Review Commission under ORS 414.690:

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

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

20 (c) Prescription drugs;

21 (d) Laboratory and X-ray services;

22 (e) Medical equipment and supplies;

23 (f) Mental health services;

24 (g) Chemical dependency services;

25 (h) Emergency dental services;

26 (i) Nonemergency dental services;

27 (j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of  
28 this subsection, defined by federal law that may be included in the state’s medical assistance pro-  
29 gram;

30 (k) Emergency hospital services;

31 (L) Outpatient hospital services; and

32 (m) Inpatient hospital services.

33 [(14)] (13) “Income” has the meaning given that term in ORS 411.704.

34 [(15)(a)] (14)(a) “Integrated health care” means care provided to individuals and their families  
35 in a patient centered primary care home or behavioral health home by licensed primary care  
36 clinicians, behavioral health clinicians and other care team members, working together to address  
37 one or more of the following:

38 (A) Mental illness.

39 (B) Substance use disorders.

40 (C) Health behaviors that contribute to chronic illness.

41 (D) Life stressors and crises.

42 (E) Developmental risks and conditions.

43 (F) Stress-related physical symptoms.

44 (G) Preventive care.

45 (H) Ineffective patterns of health care utilization.

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

2 (A) Qualified mental health professionals or qualified mental health associates meeting require-  
3 ments adopted by the Oregon Health Authority by rule;

4 (B) Peer wellness specialists;

5 (C) Peer support specialists;

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

7 (E) Personal health navigators; or

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

9 [(16)] (15) “Investments and savings” means cash, securities as defined in ORS 59.015, negotiable  
10 instruments as defined in ORS 73.0104 and such similar investments or savings as the department  
11 or the authority may establish by rule that are available to the applicant or recipient to contribute  
12 toward meeting the needs of the applicant or recipient.

13 [(17)] (16) “Medical assistance” means so much of the medical, mental health, preventive, sup-  
14 portive, palliative and remedial care and services as may be prescribed by the authority according  
15 to the standards established pursuant to ORS 414.065, including premium assistance and payments  
16 made for services provided under an insurance or other contractual arrangement and money paid  
17 directly to the recipient for the purchase of health services and for services described in ORS  
18 414.710.

19 [(18)] (17) “Medical assistance” includes any care or services for any individual who is a patient  
20 in a medical institution or any care or services for any individual who has attained 65 years of age  
21 or is under 22 years of age, and who is a patient in a private or public institution for mental dis-  
22 eases. Except as provided in ORS 411.439 and 411.447, “medical assistance” does not include care  
23 or services for a resident of a nonmedical public institution.

24 [(19)] (18) “Patient centered primary care home” means a health care team or clinic that is or-  
25 ganized in accordance with the standards established by the Oregon Health Authority under ORS  
26 414.655 and that incorporates the following core attributes:

27 (a) Access to care;

28 (b) Accountability to consumers and to the community;

29 (c) Comprehensive whole person care;

30 (d) Continuity of care;

31 (e) Coordination and integration of care; and

32 (f) Person and family centered care.

33 [(20)] (19) “Peer support specialist” means any of the following individuals who meet qualifica-  
34 tion criteria adopted by the authority under ORS 414.665 and who provide supportive services to a  
35 current or former consumer of mental health or addiction treatment:

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

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

39 [(21)] (20) “Peer wellness specialist” means an individual who meets qualification criteria  
40 adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and  
41 substance use disorder service and support needs of a member of a coordinated care organization  
42 through community outreach, assisting members with access to available services and resources,  
43 addressing barriers to services and providing education and information about available resources  
44 for individuals with mental health or substance use disorders in order to reduce stigma and dis-  
45 crimination toward consumers of mental health and substance use disorder services and to assist the

1 member in creating and maintaining recovery, health and wellness.

2 [(22)] (21) “Person centered care” means care that:

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

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

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

7 [(23)] (22) “Personal health navigator” means an individual who meets qualification criteria  
8 adopted by the authority under ORS 414.665 and who provides information, assistance, tools and  
9 support to enable a patient to make the best health care decisions in the patient’s particular cir-  
10 cumstances and in light of the patient’s needs, lifestyle, combination of conditions and desired out-  
11 comes.

12 [(24)] (23) “Prepaid managed care health services organization” means a managed dental care,  
13 mental health or chemical dependency organization that contracts with the authority under ORS  
14 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health ser-  
15 vices to medical assistance recipients.

16 [(25)] (24) “Quality measure” means the health outcome and quality measures and benchmarks  
17 identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee  
18 in accordance with ORS 413.017 (4) and 414.638.

19 [(26)] (25) “Resources” has the meaning given that term in ORS 411.704. For eligibility purposes,  
20 “resources” does not include charitable contributions raised by a community to assist with medical  
21 expenses.

22 [(27)(a)] (26)(a) “Youth support specialist” means an individual who meets qualification criteria  
23 adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides  
24 supportive services to an individual who:

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

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

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

29 (b) A “youth support specialist” may be a peer wellness specialist or a peer support specialist.

30 **SECTION 65.** ORS 414.115 is amended to read:

31 414.115. (1) In lieu of providing one or more of the health care and services available under  
32 medical assistance by direct payments to providers thereof and in lieu of providing such health care  
33 and services made available pursuant to ORS 414.065, the Oregon Health Authority may use avail-  
34 able medical assistance funds to purchase and pay premiums on policies of insurance, or enter into  
35 and pay the expenses on health care service contracts, or medical or hospital service contracts that  
36 provide one or more of the health care and services available under medical assistance.  
37 Notwithstanding other specific provisions, the use of available medical assistance funds to purchase  
38 health care and services may provide the following insurance or contract options:

39 (a) Differing services or levels of service among groups of eligibles as defined by rules of the  
40 authority; and

41 (b) Services and reimbursement for these services may vary among contracts and need not be  
42 uniform.

43 (2) The policy of insurance or the contract by its terms, or the insurer or contractor by written  
44 acknowledgment to the authority must guarantee:

45 (a) To provide health care and services of the type, within the extent and according to standards

1 prescribed under ORS 414.065;

2 (b) To pay providers of health care and services the amount due, based on the number of days  
3 of care and the fees, charges and costs established under ORS 414.065, except as to medical or  
4 hospital service contracts which employ a method of accounting or payment on other than a fee-  
5 for-service basis;

6 (c) To provide health care and services under policies of insurance or contracts in compliance  
7 with all laws, rules and regulations applicable thereto; and

8 (d) To provide such statistical data, records and reports relating to the provision, administration  
9 and costs of providing health care and services to the authority as may be required by the authority  
10 for its records, reports and audits.

11 [(3) *The authority may purchase insurance under this section through the health insurance ex-*  
12 *change.*]

13 **SECTION 66.** ORS 430.021 is amended to read:

14 430.021. Subject to ORS 417.300 and 417.305:

15 (1) The Department of Human Services shall directly or through contracts with private entities,  
16 counties under ORS 430.620 or other public entities:

17 (a) Direct, promote, correlate and coordinate all the activities, duties and direct services for  
18 persons with developmental disabilities.

19 (b) Promote, correlate and coordinate the developmental disabilities activities of all govern-  
20 mental organizations throughout the state in which there is any direct contact with developmental  
21 disabilities programs.

22 (c) Establish, coordinate, assist and direct a community developmental disabilities program in  
23 cooperation with local government units and integrate such a program with the state developmental  
24 disabilities program.

25 (d) Promote public education in this state concerning developmental disabilities and act as the  
26 liaison center for work with all interested public and private groups and agencies in the field of  
27 developmental disabilities services.

28 (2) The Oregon Health Authority shall directly or by contract with private or public entities:

29 (a) Direct, promote, correlate and coordinate all the activities, duties and direct services for  
30 persons with mental or emotional disturbances, alcoholism or drug dependence.

31 (b) Promote, correlate and coordinate the mental health activities of all governmental organ-  
32 izations throughout the state in which there is any direct contact with mental health programs.

33 (c) Establish, coordinate, assist and direct a community mental health program in cooperation  
34 with local government units and integrate such a program with the state mental health program.

35 (d) Promote public education in this state concerning mental health and act as the liaison center  
36 for work with all interested public and private groups and agencies in the field of mental health  
37 services.

38 (3) The department and the authority shall develop cooperative programs with interested private  
39 groups throughout the state to effect better community awareness and action in the fields of mental  
40 health and developmental disabilities, and encourage and assist in all necessary ways community  
41 general hospitals to establish psychiatric services.

42 (4) To the greatest extent possible, the least costly settings for treatment, outpatient services  
43 and residential facilities shall be widely available and utilized except when contraindicated because  
44 of individual health care needs. State agencies that purchase treatment for mental or emotional  
45 disturbances shall develop criteria consistent with this policy. [*In reviewing applications for certif-*

1 *icates of need, the Director of the Oregon Health Authority shall take this policy into account.]*

2 (5) The department and the authority shall accept the custody of persons committed to its care  
3 by the courts of this state.

4 (6) The authority shall adopt rules to require a facility and a nonhospital facility as those terms  
5 are defined in ORS 426.005, and a provider that employs a person described in ORS 426.415, if sub-  
6 ject to authority rules regarding the use of restraint or seclusion during the course of mental health  
7 treatment of a child or adult, to report to the authority each calendar quarter the number of inci-  
8 dents involving the use of restraint or seclusion. The aggregate data shall be made available to the  
9 public.

10 **SECTION 67.** ORS 430.315 is amended to read:

11 430.315. The Legislative Assembly finds alcoholism or drug dependence is an illness. The alco-  
12 holic or drug-dependent person is ill and should be afforded treatment for that illness. To the  
13 greatest extent possible, the least costly settings for treatment, outpatient services and residential  
14 facilities shall be widely available and utilized except when contraindicated because of individual  
15 health care needs. State agencies that purchase treatment for alcoholism or drug dependence shall  
16 develop criteria consistent with this policy in consultation with the Oregon Health Authority. In  
17 reviewing applications for certificate of need, the [*Director of the Oregon Health Authority*] **De-**  
18 **partment of Human Services** shall take this policy into account.

19 **SECTION 68.** ORS 441.065, as amended by section 14, chapter 50, Oregon Laws 2018, is  
20 amended to read:

21 441.065. (1) ORS 441.015 to 441.087 and 441.196 or the rules adopted pursuant thereto do not  
22 authorize the supervision, regulation or control of the remedial care or treatment of residents or  
23 patients in any home or institution that is described under subsection (2) of this section and is  
24 conducted for those who rely upon treatment solely by prayer or spiritual means, except as to the  
25 sanitary and safe conditions of the premises, cleanliness of operation and its physical equipment.  
26 This section does not exempt such a home or institution from the licensing requirements of ORS  
27 441.015 to 441.087, 441.525 to 441.595, 441.815, 441.820[,] **and** 441.990[, *442.342 and 442.344*].

28 (2) To qualify under subsection (1) of this section, a home or institution must:

29 (a) Be owned by an entity that is registered with the Secretary of State as a nonprofit corpo-  
30 ration and that does not own, hold a financial interest in, control or operate any facility, wherever  
31 located, of a type providing medical health care and services; and

32 (b) Provide 24 hour a day availability of nonmedical care and services.

33 (3) As used in this section:

34 (a) "Medical health care and services" means medical screening, examination, diagnosis,  
35 prognosis, treatment and drug administration. "Medical health care and services" does not include  
36 counseling or the provision of social services or dietary services.

37 (b) "Nonmedical care and services" means assistance or services, other than medical health care  
38 and services, provided by attendants for the physical, mental, emotional or spiritual comfort and  
39 well being of residents or patients.

40 **SECTION 69.** ORS 441.550 is amended to read:

41 441.550. Except as otherwise provided in ORS 441.545, an authority shall have all powers nec-  
42 essary to accomplish the purpose of providing hospital facilities for the people of Oregon, including  
43 without limitation the power:

44 (1) To sue and be sued in its own name.

45 (2) To acquire by purchase, construction, exchange, gift, lease, or otherwise, and to improve,

1 extend, maintain, equip and furnish hospital facilities, which hospital facilities may be either within  
2 or without the corporate limits of the municipality by which the authority is created.

3 (3) To lease such hospital facilities to any one or more political subdivisions of this state or any  
4 private nonprofit corporations [*which*] **that** are operating or propose to operate an inpatient care  
5 facility subject to the licensing and supervision requirements of ORS 441.015 to 441.087, 441.525 to  
6 441.595, 441.815, 441.820, 441.990[ *442.342, 442.344*] and 442.400 to 442.463 upon such terms and  
7 conditions as the board deems appropriate, to charge and collect rents and to terminate any such  
8 lease upon default of the lessee.

9 (4) To enter into options and agreements for the renewal or extension of such leases of hospital  
10 facilities or for the conveyance of such hospital facilities.

11 (5) To sell, exchange, donate and convey any or all of its hospital facilities or other assets.

12 (6) To borrow money and to issue notes and revenue bonds for the purpose of carrying out its  
13 powers.

14 (7) To mortgage and pledge its assets, or any portion thereof, whether then owned or thereafter  
15 acquired, to pledge the revenues and receipts from such assets, to acquire, hold, and dispose of  
16 mortgages and other similar documents relating to hospital facilities, and to arrange and provide for  
17 guarantee and other security agreements therefor.

18 (8) To loan money for the construction of and improvements to hospital facilities.

19 (9) To enter into contracts, leases and other undertakings in its own name.

20 (10) To adopt and amend ordinances and resolutions.

21 **SECTION 70.** ORS 441.710 is amended to read:

22 441.710. (1)(a) In addition to any other liability or penalty provided by law, the Director of Hu-  
23 man Services may impose a civil penalty on a person pursuant to ORS 441.731 for any of the fol-  
24 lowing:

25 (A) Violation of any of the terms or conditions of a license issued under ORS 441.015 to 441.087,  
26 441.525 to 441.595, 441.815, 441.820, 441.990[ *442.342, 442.344*] and 442.400 to 442.463 for a long term  
27 care facility, as defined in ORS 442.015.

28 (B) Violation of ORS 441.630 to 441.680.

29 (C) Violation of any rule or general order of the Department of Human Services that pertains  
30 to a long term care facility.

31 (D) Violation of any final order of the director that pertains specifically to the long term care  
32 facility owned or operated by the person incurring the penalty.

33 (E) Violation of ORS 441.605 or of rules required to be adopted under ORS 441.610.

34 (F) Violation of ORS 443.880 or 443.881 if the facility is a residential care facility.

35 (b) In addition to any other liability or penalty provided by law, the director may impose a civil  
36 penalty on a residential training facility or residential training home for violation of ORS 443.880  
37 or 443.881. The director shall prescribe a reasonable time for elimination of a violation by a resi-  
38 dential training facility or residential training home:

39 (A) Not to exceed 30 days after first notice of a violation; or

40 (B) In cases where the violation requires more than 30 days to correct, such time as is specified  
41 in a plan of correction found acceptable by the director.

42 (2) In addition to any other liability or penalty provided by law, the Director of the Oregon  
43 Health Authority may impose a civil penalty on a person for a violation of ORS 443.880 or 443.881  
44 if the facility is a residential treatment facility or a residential treatment home.

45 (3) The Director of Human Services may not impose a penalty under subsection (1) of this sec-

1 tion for violations other than those involving direct patient care or feeding, an adequate staff to  
 2 patient ratio, sanitation involving direct patient care or a violation of ORS 441.605 or 443.880 or  
 3 443.881 or of the rules required to be adopted by ORS 441.610 unless a violation is found on two  
 4 consecutive surveys of a long term care facility.

5 (4) The Director of the Oregon Health Authority may not impose a penalty under subsection (2)  
 6 of this section for violations other than those involving direct patient care or feeding, an adequate  
 7 staff to patient ratio, sanitation involving direct patient care or a violation of ORS 443.880 or  
 8 443.881. The director in every case shall prescribe a reasonable time for elimination of a violation:

9 (a) Not to exceed 30 days after first notice of a violation; or

10 (b) In cases where the violation requires more than 30 days to correct, such time as is specified  
 11 in a plan of correction found acceptable by the director.

12 **SECTION 71.** ORS 442.015, as amended by section 22, chapter 608, Oregon Laws 2013, and  
 13 section 6, chapter 50, Oregon Laws 2018, is amended to read:

14 442.015. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

15 (1) “Acquire” or “acquisition” means obtaining equipment, supplies, components or facilities by  
 16 any means, including purchase, capital or operating lease, rental or donation, for the purpose of  
 17 using such equipment, supplies, components or facilities to provide health services in Oregon. When  
 18 equipment or other materials are obtained outside of this state, acquisition is considered to occur  
 19 when the equipment or other materials begin to be used in Oregon for the provision of health ser-  
 20 vices or when such services are offered for use in Oregon.

21 (2) “Affected persons” has the same meaning as given to “party” in ORS 183.310.

22 (3)(a) “Ambulatory surgical center” means a facility or portion of a facility that operates ex-  
 23 clusively for the purpose of providing surgical services to patients who do not require  
 24 hospitalization and for whom the expected duration of services does not exceed 24 hours following  
 25 admission.

26 (b) “Ambulatory surgical center” does not mean:

27 (A) Individual or group practice offices of private physicians or dentists that do not contain a  
 28 distinct area used for outpatient surgical treatment on a regular and organized basis, or that only  
 29 provide surgery routinely provided in a physician’s or dentist’s office using local anesthesia or  
 30 conscious sedation; or

31 (B) A portion of a licensed hospital designated for outpatient surgical treatment.

32 (4) “Delegated credentialing agreement” means a written agreement between an originating-site  
 33 hospital and a distant-site hospital that provides that the medical staff of the originating-site hospi-  
 34 tal will rely upon the credentialing and privileging decisions of the distant-site hospital in making  
 35 recommendations to the governing body of the originating-site hospital as to whether to credential  
 36 a telemedicine provider, practicing at the distant-site hospital either as an employee or under con-  
 37 tract, to provide telemedicine services to patients in the originating-site hospital.

38 (5) “Develop” means to undertake those activities that on their completion will result in the  
 39 offer of a new institutional health service or the incurring of a financial obligation, as defined under  
 40 applicable state law, in relation to the offering of such a health service.

41 (6) “Distant-site hospital” means the hospital where a telemedicine provider, at the time the  
 42 telemedicine provider is providing telemedicine services, is practicing as an employee or under  
 43 contract.

44 (7) “Expenditure” or “capital expenditure” means the actual expenditure, an obligation to an  
 45 expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a



1 donation or grant in lieu of an expenditure but not including any interest thereon.

2 (8) "Extended stay center" means a facility licensed in accordance with section 2, chapter 50,  
3 Oregon Laws 2018.

4 (9) "Freestanding birthing center" means a facility licensed for the primary purpose of per-  
5 forming low risk deliveries.

6 (10) "Governmental unit" means the state, or any county, municipality or other political subdi-  
7 vision, or any related department, division, board or other agency.

8 (11) "Gross revenue" means the sum of daily hospital service charges, ambulatory service  
9 charges, ancillary service charges and other operating revenue. "Gross revenue" does not include  
10 contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

11 (12)(a) "Health care facility" means:

12 (A) A hospital;

13 (B) A long term care facility;

14 (C) An ambulatory surgical center;

15 (D) A freestanding birthing center;

16 (E) An outpatient renal dialysis facility; or

17 (F) An extended stay center.

18 (b) "Health care facility" does not mean:

19 (A) A residential facility licensed by the Department of Human Services or the Oregon Health  
20 Authority under ORS 443.415;

21 (B) An establishment furnishing primarily domiciliary care as described in ORS 443.205;

22 (C) A residential facility licensed or approved under the rules of the Department of Corrections;

23 (D) Facilities established by ORS 430.335 for treatment of substance abuse disorders; or

24 (E) Community mental health programs or community developmental disabilities programs es-  
25 tablished under ORS 430.620.

26 (13) "Health maintenance organization" or "HMO" means a public organization or a private  
27 organization organized under the laws of any state that:

28 (a) Is a qualified HMO under section 1310(d) of the U.S. Public Health Services Act; or

29 (b)(A) Provides or otherwise makes available to enrolled participants health care services, in-  
30 cluding at least the following basic health care services:

31 (i) Usual physician services;

32 (ii) Hospitalization;

33 (iii) Laboratory;

34 (iv) X-ray;

35 (v) Emergency and preventive services; and

36 (vi) Out-of-area coverage;

37 (B) Is compensated, except for copayments, for the provision of the basic health care services  
38 listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic  
39 rate basis; and

40 (C) Provides physicians' services primarily directly through physicians who are either employees  
41 or partners of such organization, or through arrangements with individual physicians or one or more  
42 groups of physicians organized on a group practice or individual practice basis.

43 (14) "Health services" means clinically related diagnostic, treatment or rehabilitative services,  
44 and includes alcohol, drug or controlled substance abuse and mental health services that may be  
45 provided either directly or indirectly on an inpatient or ambulatory patient basis.

1 (15) "Hospital" means:

2 (a) A facility with an organized medical staff and a permanent building that is capable of pro-  
3 viding 24-hour inpatient care to two or more individuals who have an illness or injury and that  
4 provides at least the following health services:

5 (A) Medical;

6 (B) Nursing;

7 (C) Laboratory;

8 (D) Pharmacy; and

9 (E) Dietary; or

10 (b) A special inpatient care facility as that term is defined by the authority by rule.

11 (16) "Institutional health services" means health services provided in or through health care  
12 facilities and the entities in or through which such services are provided.

13 (17) "Intermediate care facility" means a facility that provides, on a regular basis, health-related  
14 care and services to individuals who do not require the degree of care and treatment that a hospital  
15 or skilled nursing facility is designed to provide, but who because of their mental or physical con-  
16 dition require care and services above the level of room and board that can be made available to  
17 them only through institutional facilities.

18 (18)(a) "Long term care facility" means a permanent facility with inpatient beds, providing:

19 (A) Medical services, including nursing services but excluding surgical procedures except as  
20 may be permitted by the rules of the Director of Human Services; and

21 (B) Treatment for two or more unrelated patients.

22 (b) "Long term care facility" includes skilled nursing facilities and intermediate care facilities  
23 but does not include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

24 [(19) "New hospital" means:]

25 [(a) A facility that did not offer hospital services on a regular basis within its service area within  
26 the prior 12-month period and is initiating or proposing to initiate such services; or]

27 [(b) Any replacement of an existing hospital that involves a substantial increase or change in the  
28 services offered.]

29 [(20)] (19) "New skilled nursing or intermediate care service or facility" means a service or fa-  
30 cility that did not offer long term care services on a regular basis by or through the facility within  
31 the prior 12-month period and is initiating or proposing to initiate such services. "New skilled  
32 nursing or intermediate care service or facility" also includes the rebuilding of a long term care  
33 facility, the relocation of buildings that are a part of a long term care facility, the relocation of long  
34 term care beds from one facility to another or an increase in the number of beds of more than 10  
35 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period.

36 [(21)] (20) "Offer" means that the health care facility holds itself out as capable of providing,  
37 or as having the means for the provision of, specified health services.

38 [(22)] (21) "Originating-site hospital" means a hospital in which a patient is located while re-  
39 ceiving telemedicine services.

40 [(23)] (22) "Outpatient renal dialysis facility" means a facility that provides renal dialysis ser-  
41 vices directly to outpatients.

42 [(24)] (23) "Person" means an individual, a trust or estate, a partnership, a corporation (includ-  
43 ing associations, joint stock companies and insurance companies), a state, or a political subdivision  
44 or instrumentality, including a municipal corporation, of a state.

45 [(25)] (24) "Skilled nursing facility" means a facility or a distinct part of a facility, that is pri-

1 marily engaged in providing to inpatients skilled nursing care and related services for patients who  
 2 require medical or nursing care, or an institution that provides rehabilitation services for the re-  
 3 habilitation of individuals who are injured or sick or who have disabilities.

4 [(26)] (25) "Telemedicine" means the provision of health services to patients by physicians and  
 5 health care practitioners from a distance using electronic communications.

6 **SECTION 72.** ORS 442.394 is amended to read:

7 442.394. (1) A hospital or ambulatory surgical center shall bill and accept as payment in full  
 8 [an amount determined in accordance with ORS 243.256 and 243.879, if applicable, or] the payment  
 9 methodology prescribed by the Oregon Health Authority under ORS 442.392.

10 (2) This section does not apply to type A or type B hospitals, as described in ORS 442.470, or  
 11 rural critical access hospitals, as defined in ORS 442.470.

12 **SECTION 73.** ORS 442.396 is amended to read:

13 442.396. An insurer, as defined in ORS 731.106, that contracts with the Oregon Health Authority,  
 14 including with the Public Employees' Benefit Board and the Oregon Educators Benefit Board, to  
 15 provide health insurance coverage for state employees, educators or medical assistance recipients  
 16 must annually attest, on a form and in a manner prescribed by the authority, to its compliance with  
 17 ORS [243.256, 243.879,] 442.392 and 442.394. A contract with an insurer subject to the requirements  
 18 of this section may not be renewed without the attestation required by this section.

19 **SECTION 74.** ORS 471.752 is amended to read:

20 471.752. (1) An agent appointed under ORS 471.750 may participate in a **supplemental** health  
 21 benefit plan available to state employees pursuant to ORS 243.105 to 243.285 at the expense of the  
 22 agent and may participate in the state deferred compensation plan established under ORS 243.401  
 23 to 243.507. For such purposes, agents shall be considered eligible state employees.

24 (2) A person who is the surviving spouse or child of a deceased agent or the spouse or child of  
 25 an agent of the Oregon Liquor Control Commission who has a disability shall be given preference  
 26 in the appointment of a successor agent, if otherwise qualified, the spouse having greater preference.  
 27 The experience of such applicant in the business operation of the deceased agent or the agent who  
 28 has a disability shall be the primary consideration in determining the qualifications of the applicant.

29 **SECTION 75.** ORS 479.210 is amended to read:

30 479.210. As used in ORS 479.215 to 479.220, unless the context requires otherwise, "institution"  
 31 means:

32 (1) A child-caring facility that provides residential care and that receives state aid under ORS  
 33 412.001 to 412.161, 418.005 to 418.025, 418.205 to 418.327, 418.470, 418.475, 418.625 to 418.685, 418.647  
 34 and 418.950 to 418.970;

35 (2) An inpatient care facility required to be licensed under ORS 441.015 to 441.087, 441.525 to  
 36 441.595, 441.815, 441.820, 441.990[, 442.342, 442.344] and 442.400 to 442.463; or

37 (3) A residential facility subject to licensure under ORS 443.400 to 443.455.

38 **SECTION 76.** ORS 677.450 is amended to read:

39 677.450. The Oregon Medical Board may release information received under ORS 441.820 con-  
 40 cerning the revocation or restriction of a physician's activities at a health care facility to any other  
 41 health care facility licensed under ORS 441.015 to 441.087, 441.525 to 441.595, 441.815, 441.820,  
 42 441.990[, 442.342, 442.344] and 442.400 to 442.463 at which that physician holds or has applied for  
 43 staff privileges or other right to practice medicine or podiatry at the facility.

44 **SECTION 77.** ORS 742.400 is amended to read:

45 742.400. (1) As used in this section:

1 (a) "Claim" means a written demand for payment from or on behalf of a covered practitioner for  
2 an injury alleged to have been caused by professional negligence that is made in a complaint filed  
3 with a court of appropriate jurisdiction.

4 (b) "Covered practitioner" means a chiropractic physician, physician or physician assistant li-  
5 censed under ORS chapter 677, nurse practitioner, optometrist, dentist, dental hygienist or  
6 naturopath.

7 (c) "Disposition of a claim" means:

8 (A) A judgment or award against the covered practitioner by a court, a jury or an arbitrator;

9 (B) A withdrawal or dismissal of the claim; or

10 (C) A settlement of the claim.

11 (d) "Reporter" means:

12 (A) A primary insurer;

13 (B) A public body required to defend, save harmless and indemnify an officer, employee or agent  
14 of the public body under ORS 30.260 to 30.300;

15 (C) An entity that self-insures or indemnifies for claims alleging professional negligence on the  
16 part of a covered practitioner; or

17 (D) A health maintenance organization as defined in ORS 750.005.

18 (2) Within 30 days after receiving notice of a claim, a reporter shall report the claim to the  
19 appropriate board, as follows:

20 (a) The Oregon Medical Board if the covered practitioner is a physician or physician assistant  
21 licensed under ORS chapter 677;

22 (b) The Oregon State Board of Nursing if the covered practitioner is a nurse practitioner;

23 (c) The Oregon Board of Optometry if the covered practitioner is an optometrist;

24 (d) The Oregon Board of Dentistry if the covered practitioner is a dentist or dental hygienist;

25 (e) The Oregon Board of Naturopathic Medicine if the covered practitioner is a naturopath; or

26 (f) The State Board of Chiropractic Examiners if the covered practitioner is a chiropractic  
27 physician.

28 (3) The report required under subsection (2) of this section shall include:

29 (a) The name of the covered practitioner;

30 (b) The name of the person that filed the claim;

31 (c) The date on which the claim was filed; and

32 (d) The reason or reasons for the claim, except that the report may not disclose any data that  
33 is privileged under ORS 41.675.

34 (4) Within 30 days after the date of an action taken in disposition of a claim, a reporter shall  
35 notify the appropriate board identified in subsection (2) of this section of the disposition.

36 (5)(a) A board that receives a report of a claim under this section shall publicly post the report  
37 on the board's website if the claim results in a judicial finding or admission of liability or a money  
38 judgment, award or settlement that involves a payment to the claimant. The board may not publicly  
39 post information about claims that did not result in a judicial finding or admission of liability or a  
40 money judgment, award or settlement that involves a payment to the claimant but shall make the  
41 information available to the public upon request.

42 (b) If a board discloses information about a claim that is the subject of a report received under  
43 this section, the board shall indicate in the disclosure whether the claim resulted in a judicial  
44 finding or an admission of liability or a money judgment, an award or a settlement that involves a  
45 payment to the claimant. A board may not publicly disclose or publish any allegations or factual

1 assertions included in the claim unless the complaint resulted in a judicial finding or an admission  
2 of liability or a money judgment, an award or a settlement that involves a payment to the claimant.

3 (c) For purposes of this subsection, “judicial finding” means a finding of liability by a court, a  
4 jury or an arbitrator.

5 (6) A board that receives a report under this section shall provide copies of the report to each  
6 health care facility licensed under ORS 441.015 to 441.087, 441.525 to 441.595, 441.815, 441.820,  
7 441.990[*442.342, 442.344*] and 442.400 to 442.463 that employs or grants staff privileges to the cov-  
8 ered practitioner.

9 (7) A person that reports in good faith concerning any matter required to be reported under this  
10 section is immune from civil liability by reason of making the report.

11 **SECTION 78.** ORS 743A.001 is amended to read:

12 743A.001. (1) [*Except as provided in subsection (4) of this section,*] Any statute described in sub-  
13 section (2) of this section:

14 (a) That becomes effective on or after July 13, 1985, is repealed on the sixth anniversary of the  
15 effective date of the statute, unless the Legislative Assembly specifically provides otherwise[.]; **and**

16 (b) **Does not apply to any insurer with respect to services covered in the Health Care for**  
17 **All Oregon Plan.**

18 (2) This section governs any statute that applies to individual or group health insurance policies  
19 and does any of the following:

20 (a) Requires the insurer to include coverage for specific physical or mental conditions or specific  
21 hospital, medical, surgical or dental health services.

22 (b) Requires the insurer to include coverage for specified persons.

23 (c) Requires the insurer to provide payment or reimbursement to specified providers of services  
24 if the services are within the lawful scope of practice of the provider and the insurance policy pro-  
25 vides payment or reimbursement for those services.

26 (d) Requires the insurer to provide any specific coverage on a nondiscriminatory basis.

27 (e) Forbids the insurer to exclude from payment or reimbursement any covered services.

28 (f) Forbids the insurer to exclude coverage of a person because of that person’s medical history.

29 (3) A repeal of a statute under subsection (1)(a) of this section does not apply to any insurance  
30 policy in effect on the effective date of the repeal. However, the repeal of the statute applies to a  
31 renewal or extension of an existing insurance policy on or after the effective date of the repealer  
32 as well as to a new policy issued on or after the effective date of the repealer.

33 (4) [*This section*] **Subsection (1)(a) of this section** does not apply to ORS 743A.020, 743A.080,  
34 743A.100, 743A.104 and 743A.108.

35 **SECTION 79.** ORS 743A.012 is amended to read:

36 743A.012. (1) As used in this section:

37 (a) “Behavioral health assessment” means an evaluation by a behavioral health clinician, in  
38 person or using telemedicine, to determine a patient’s need for immediate crisis stabilization.

39 (b) “Behavioral health clinician” means:

40 (A) A licensed psychiatrist;

41 (B) A licensed psychologist;

42 (C) A certified nurse practitioner with a specialty in psychiatric mental health;

43 (D) A licensed clinical social worker;

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

45 (F) A certified clinical social work associate;

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

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

5 (c) “Behavioral health crisis” means a disruption in an individual’s mental or emotional stability  
6 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-  
7 partment or admission to a hospital to prevent a serious deterioration in the individual’s mental or  
8 physical health.

9 (d) “Emergency medical condition” means a medical condition:

10 (A) That manifests itself by acute symptoms of sufficient severity, including severe pain, that a  
11 prudent layperson possessing an average knowledge of health and medicine would reasonably expect  
12 that failure to receive immediate medical attention would:

13 (i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious  
14 jeopardy;

15 (ii) Result in serious impairment to bodily functions; or

16 (iii) Result in serious dysfunction of any bodily organ or part;

17 (B) With respect to a pregnant woman who is having contractions, for which there is inadequate  
18 time to effect a safe transfer to another hospital before delivery or for which a transfer may pose  
19 a threat to the health or safety of the woman or the unborn child; or

20 (C) That is a behavioral health crisis.

21 (e) “Emergency medical screening exam” means the medical history, examination, ancillary tests  
22 and medical determinations required to ascertain the nature and extent of an emergency medical  
23 condition.

24 (f) “Emergency services” means, with respect to an emergency medical condition:

25 (A) An emergency medical screening exam or behavioral health assessment that is within the  
26 capability of the emergency department of a hospital, including ancillary services routinely available  
27 to the emergency department to evaluate such emergency medical condition; and

28 (B) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to  
29 stabilize a patient, to the extent the examination and treatment are within the capability of the staff  
30 and facilities available at a hospital.

31 (g) “Grandfathered health plan” has the meaning given that term in ORS 743B.005.

32 (h) “Health benefit plan” has the meaning given that term in ORS 743B.005.

33 (i) “Prior authorization” has the meaning given that term in ORS 743B.001.

34 (j) “Stabilize” means to provide medical treatment as necessary to:

35 (A) Ensure that, within reasonable medical probability, no material deterioration of an emer-  
36 gency medical condition is likely to occur during or to result from the transfer of the patient from  
37 a facility; and

38 (B) With respect to a pregnant woman who is in active labor, to perform the delivery, including  
39 the delivery of the placenta.

40 (2) All insurers offering a health benefit plan shall provide coverage without prior authorization  
41 for emergency services.

42 (3) **Except as provided in section 5 of this 2019 Act**, a health benefit plan, other than a  
43 grandfathered health plan, must provide coverage required by subsection (2) of this section:

44 (a) For the services of participating providers, without regard to any term or condition of cov-  
45 erage other than:

- 1 (A) The coordination of benefits;
- 2 (B) An affiliation period or waiting period permitted under part 7 of the Employee Retirement  
3 Income Security Act, part A of Title XXVII of the Public Health Service Act or chapter 100 of the  
4 Internal Revenue Code;
- 5 (C) An exclusion other than an exclusion of emergency services; or
- 6 (D) Applicable cost-sharing; and
- 7 (b) For the services of a nonparticipating provider:
- 8 (A) Without imposing any administrative requirement or limitation on coverage that is more  
9 restrictive than requirements or limitations that apply to participating providers;
- 10 (B) Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate  
11 for participating providers;
- 12 (C) Without imposing a deductible, unless the deductible applies generally to nonparticipating  
13 providers; and
- 14 (D) Subject only to an out-of-pocket maximum that applies to all services from nonparticipating  
15 providers.
- 16 (4) All insurers offering a health benefit plan shall provide information to enrollees in plain  
17 language regarding:
- 18 (a) What constitutes an emergency medical condition;
- 19 (b) The coverage provided for emergency services;
- 20 (c) How and where to obtain emergency services; and
- 21 (d) The appropriate use of 9-1-1.
- 22 (5) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and  
23 may not deny coverage for emergency services solely because 9-1-1 was used.
- 24 (6) This section is exempt from ORS 743A.001.
- 25 **SECTION 80.** ORS 743A.063 is amended to read:
- 26 743A.063. (1) **Except as provided in section 5 of this 2019 Act**, a prescription drug benefit  
27 program, or a prescription drug benefit offered under a health benefit plan as defined in ORS  
28 743B.005, must provide for reimbursement for up to a 90-day supply of a prescription drug dispensed  
29 by a pharmacy, as defined in ORS 689.005, if:
- 30 (a) The prescription drug is covered by the program or plan;
- 31 (b) An initial 30-day supply of the prescription drug has been previously dispensed to the pro-  
32 gram or plan member; and
- 33 (c) The quantity of the prescription drug dispensed does not exceed the total remaining quantity  
34 of the prescription drug that the prescribing practitioner authorized to be dispensed through refills.
- 35 (2) The coverage required by subsection (1) of this section may be limited by the terms and  
36 conditions of a pharmacy network contract, or a prescription drug benefit program or health benefit  
37 plan, that are related to the reimbursement rate of the prescription drug.
- 38 (3) The coverage required by subsection (1) of this section may be limited by formulary re-  
39 strictions that are related to the prescription drug.
- 40 (4) This section does not apply to the reimbursement of prescription drugs classified as a con-  
41 trolled substance in Schedule II.
- 42 (5) This section is exempt from ORS 743A.001.
- 43 **SECTION 81.** ORS 743A.067 is amended to read:
- 44 743A.067. (1) As used in this section:
- 45 (a) “Contraceptives” means health care services, drugs, devices, products or medical procedures

1 to prevent a pregnancy.

2 (b) “Enrollee” means an insured individual and the individual’s spouse, domestic partner and  
3 dependents who are beneficiaries under the insured individual’s health benefit plan.

4 (c) “Health benefit plan” has the meaning given that term in ORS 743B.005, excluding Medicare  
5 Advantage Plans and including health benefit plans offering pharmacy benefits administered by a  
6 third party administrator or pharmacy benefit manager.

7 (d) “Religious employer” has the meaning given that term in ORS 743A.066.

8 (2) **Except as provided in section 5 of this 2019 Act**, a health benefit plan offered in this state  
9 must provide coverage for all of the following services, drugs, devices, products and procedures:

10 (a) Well-woman care prescribed by the Department of Consumer and Business Services by rule  
11 consistent with guidelines published by the United States Health Resources and Services Adminis-  
12 tration.

13 (b) Counseling for sexually transmitted infections, including but not limited to human  
14 immunodeficiency virus and acquired immune deficiency syndrome.

15 (c) Screening for:

16 (A) Chlamydia;

17 (B) Gonorrhea;

18 (C) Hepatitis B;

19 (D) Hepatitis C;

20 (E) Human immunodeficiency virus and acquired immune deficiency syndrome;

21 (F) Human papillomavirus;

22 (G) Syphilis;

23 (H) Anemia;

24 (I) Urinary tract infection;

25 (J) Pregnancy;

26 (K) Rh incompatibility;

27 (L) Gestational diabetes;

28 (M) Osteoporosis;

29 (N) Breast cancer; and

30 (O) Cervical cancer.

31 (d) Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic  
32 mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indi-  
33 cated.

34 (e) Screening and appropriate counseling or interventions for:

35 (A) Tobacco use; and

36 (B) Domestic and interpersonal violence.

37 (f) Folic acid supplements.

38 (g) Abortion.

39 (h) Breastfeeding comprehensive support, counseling and supplies.

40 (i) Breast cancer chemoprevention counseling.

41 (j) Any contraceptive drug, device or product approved by the United States Food and Drug  
42 Administration, subject to all of the following:

43 (A) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by  
44 the United States Food and Drug Administration, a health benefit plan may provide coverage for  
45 either the requested contraceptive drug, device or product or for one or more therapeutic equiv-



1 alents of the requested drug, device or product.

2 (B) If a contraceptive drug, device or product covered by the health benefit plan is deemed  
3 medically inadvisable by the enrollee's provider, the health benefit plan must cover an alternative  
4 contraceptive drug, device or product prescribed by the provider.

5 (C) A health benefit plan must pay pharmacy claims for reimbursement of all contraceptive  
6 drugs available for over-the-counter sale that are approved by the United States Food and Drug  
7 Administration.

8 (D) A health benefit plan may not infringe upon an enrollee's choice of contraceptive drug, de-  
9 vice or product and may not require prior authorization, step therapy or other utilization control  
10 techniques for medically appropriate covered contraceptive drugs, devices or other products ap-  
11 proved by the United States Food and Drug Administration.

12 (k) Voluntary sterilization.

13 (L) As a single claim or combined with other claims for covered services provided on the same  
14 day:

15 (A) Patient education and counseling on contraception and sterilization.

16 (B) Services related to sterilization or the administration and monitoring of contraceptive drugs,  
17 devices and products, including but not limited to:

18 (i) Management of side effects;

19 (ii) Counseling for continued adherence to a prescribed regimen;

20 (iii) Device insertion and removal; and

21 (iv) Provision of alternative contraceptive drugs, devices or products deemed medically appro-  
22 priate in the judgment of the enrollee's provider.

23 (m) Any additional preventive services for women that must be covered without cost sharing  
24 under 42 U.S.C. 300gg-13, as identified by the United States Preventive Services Task Force or the  
25 Health Resources and Services Administration of the United States Department of Health and Hu-  
26 man Services as of January 1, 2017.

27 (3) A health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment  
28 or any other cost-sharing requirement on the coverage required by this section. A health care pro-  
29 vider shall be reimbursed for providing the services described in this section without any deduction  
30 for coinsurance, copayments or any other cost-sharing amounts.

31 (4) Except as authorized under this section, a health benefit plan may not impose any re-  
32 strictions or delays on the coverage required by this section.

33 (5) This section does not exclude coverage for contraceptive drugs, devices or products pre-  
34 scribed by a provider, acting within the provider's scope of practice, for:

35 (a) Reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer  
36 or eliminating symptoms of menopause; or

37 (b) Contraception that is necessary to preserve the life or health of an enrollee.

38 (6) This section does not limit the authority of the Department of Consumer and Business Ser-  
39 vices to ensure compliance with ORS 743A.063 and 743A.066.

40 (7) This section does not require a health benefit plan to cover:

41 (a) Experimental or investigational treatments;

42 (b) Clinical trials or demonstration projects, except as provided in ORS 743A.192;

43 (c) Treatments that do not conform to acceptable and customary standards of medical practice;

44 (d) Treatments for which there is insufficient data to determine efficacy; or

45 (e) Abortion if the insurer offering the health benefit plan excluded coverage for abortion in all

1 of its individual, small employer and large employer group plans during the 2017 plan year.

2 (8) If services, drugs, devices, products or procedures required by this section are provided by  
3 an out-of-network provider, the health benefit plan must cover the services, drugs, devices, products  
4 or procedures without imposing any cost-sharing requirement on the enrollee if:

5 (a) There is no in-network provider to furnish the service, drug, device, product or procedure  
6 that is geographically accessible or accessible in a reasonable amount of time, as defined by the  
7 Department of Consumer and Business Services by rule consistent with the requirements for pro-  
8 vider networks in ORS 743B.505; or

9 (b) An in-network provider is unable or unwilling to provide the service in a timely manner.

10 (9) An insurer may offer to a religious employer a health benefit plan that does not include  
11 coverage for contraceptives or abortion procedures that are contrary to the religious employer's  
12 religious tenets only if the insurer notifies in writing all employees who may be enrolled in the  
13 health benefit plan of the contraceptives and procedures the employer refuses to cover for religious  
14 reasons.

15 (10) If the Department of Consumer and Business Services concludes that enforcement of this  
16 section may adversely affect the allocation of federal funds to this state, the department may grant  
17 an exemption to the requirements but only to the minimum extent necessary to ensure the continued  
18 receipt of federal funds.

19 (11) An insurer that is subject to this section shall make readily accessible to enrollees and  
20 potential enrollees, in a consumer-friendly format, information about the coverage of contraceptives  
21 by each health benefit plan and the coverage of other services, drugs, devices, products and proce-  
22 dures described in this section. The insurer must provide the information:

23 (a) On the insurer's website; and

24 (b) In writing upon request by an enrollee or potential enrollee.

25 (12) This section does not prohibit an insurer from using reasonable medical management tech-  
26 niques to determine the frequency, method, treatment or setting for the coverage of services, drugs,  
27 devices, products and procedures described in subsection (2) of this section, other than coverage  
28 required by subsection (2)(g) and (j) of this section, if the techniques:

29 (a) Are consistent with the coverage requirements of subsection (2) of this section; and

30 (b) Do not result in the wholesale or indiscriminate denial of coverage for a service.

31 **SECTION 82.** ORS 743A.070 is amended to read:

32 743A.070. (1) **Except as provided in section 5 of this 2019 Act,** all policies providing health  
33 insurance, as defined in ORS 731.162, except those policies whose coverage is limited to expenses  
34 from accidents or specific diseases that are unrelated to the coverage required by this section, shall  
35 include coverage for a nonprescription elemental enteral formula for home use, if the formula is  
36 medically necessary for the treatment of severe intestinal malabsorption and a physician has issued  
37 a written order for the formula and the formula comprises the sole source, or an essential source,  
38 of nutrition.

39 (2) The coverage required by subsection (1) of this section may be made subject to provisions  
40 of the policy that apply to other benefits under the policy including, but not limited to, provisions  
41 related to deductibles and coinsurance. Deductibles and coinsurance for elemental enteral formulas  
42 shall be no greater than those for any other treatment for the condition under the policy.

43 (3) This section is exempt from ORS 743A.001.

44 **SECTION 83.** ORS 743A.080 is amended to read:

45 743A.080. (1) As used in this section, "pregnancy care" means the care necessary to support a

1 healthy pregnancy and care related to labor and delivery.

2 (2) **Except as provided in section 5 of this 2019 Act**, all health benefit plans as defined in  
3 ORS 743B.005 must provide payment or reimbursement for expenses associated with pregnancy care  
4 and childbirth. Benefits provided under this section shall be extended to all enrollees, enrolled  
5 spouses and enrolled dependents.

6 **SECTION 84.** ORS 743A.100 is amended to read:

7 743A.100. (1) **Except as provided in section 5 of this 2019 Act**, every health insurance policy  
8 that covers hospital, medical or surgical expenses, other than coverage limited to expenses from  
9 accidents or specific diseases, shall provide coverage of mammograms as follows:

10 (a) Mammograms for the purpose of diagnosis in symptomatic or high-risk individuals at any  
11 time upon referral of an individual's health care provider; and

12 (b) An annual mammogram for the purpose of early detection for an individual 40 years of age  
13 or older, with or without referral from the individual's health care provider.

14 (2) An insurance policy described in subsection (1) of this section must not limit coverage of  
15 mammograms to the schedule provided in subsection (1) of this section if the individual is deter-  
16 mined by the individual's health care provider to be at high risk for breast cancer.

17 **SECTION 85.** ORS 743A.104 is amended to read:

18 743A.104. **Except as provided in section 5 of this 2019 Act**, all policies providing health in-  
19 surance, except those policies whose coverage is limited to expenses from accidents or specific dis-  
20 eases that are unrelated to the coverage required by this section, shall include coverage for pelvic  
21 examinations and Pap smear examinations as follows:

22 (1) Annually for individuals 18 to 64 years of age; and

23 (2) At any time upon referral of an individual's health care provider.

24 **SECTION 86.** ORS 743A.105 is amended to read:

25 743A.105. (1) **Except as provided in section 5 of this 2019 Act**, all health benefit plans, as  
26 defined in ORS 743B.005, shall include coverage of the human papillomavirus vaccine for benefi-  
27 ciaries under the health benefit plan who are at least 11 years of age but no older than 26 years of  
28 age.

29 (2) ORS 743A.001 does not apply to this section.

30 **SECTION 87.** ORS 743A.108 is amended to read:

31 743A.108. (1) **Except as provided in section 5 of this 2019 Act**, a health insurance policy that  
32 covers hospital, medical or surgical expenses, other than coverage limited to expenses from acci-  
33 dents or specific diseases, shall provide coverage for a complete and thorough physical examination  
34 of the breast, including but not limited to a clinical breast examination, performed by a health care  
35 provider to check for lumps and other changes for the purpose of early detection and prevention of  
36 breast cancer as follows:

37 (a) Annually for individuals 18 years of age and older; and

38 (b) At any time at the recommendation of an individual's health care provider.

39 (2) An insurance policy must provide coverage of physical examinations of the breast as de-  
40 scribed in subsection (1) of this section regardless of whether a health care provider performs other  
41 preventative health examinations or makes a referral for other preventative health examinations at  
42 the same time the health care provider performs the breast examination.

43 (3) This section applies to health care service contractors, as defined in ORS 750.005, and trusts  
44 carrying out a multiple employer welfare arrangement, as defined in ORS 750.301.

45 **SECTION 88.** ORS 743A.110 is amended to read:

1 743A.110. (1) As used in this section, “mastectomy” means the surgical removal of all or part  
2 of a breast or a breast tumor suspected to be malignant.

3 (2) **Except as provided in section 5 of this 2019 Act**, all insurers offering a health benefit plan  
4 as defined in ORS 743B.005 shall provide payment, coverage or reimbursement for mastectomy and  
5 for the following services related to a mastectomy as determined by the attending physician and  
6 enrollee to be part of the enrollee’s course or plan of treatment:

7 (a) All stages of reconstruction of the breast on which a mastectomy was performed, including  
8 but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;

9 (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

10 (c) Prostheses;

11 (d) Treatment of physical complications of the mastectomy, including lymphedemas; and

12 (e) Inpatient care related to the mastectomy and post-mastectomy services.

13 (3) An insurer providing coverage under subsection (2) of this section shall provide written no-  
14 tice describing the coverage to the enrollee at the time of enrollment in the health benefit plan and  
15 annually thereafter.

16 (4) A health benefit plan must provide a single determination of prior authorization for all ser-  
17 vices related to a mastectomy covered under subsection (2) of this section that are part of the  
18 enrollee’s course or plan of treatment.

19 (5) When an enrollee requests an external review of an adverse benefit determination as defined  
20 in ORS 743B.001 by the insurer regarding services described in subsection (2) of this section, the  
21 insurer or the Director of the Department of Consumer and Business Services must expedite the  
22 enrollee’s case pursuant to ORS 743B.252 (5).

23 (6) The coverage required under subsection (2) of this section is subject to the same terms and  
24 conditions in the plan that apply to other benefits under the plan.

25 (7) This section is exempt from ORS 743A.001.

26 **SECTION 89.** ORS 743A.124 is amended to read:

27 743A.124. (1) **Except as provided in section 5 of this 2019 Act**, a health benefit plan, as de-  
28 fined in ORS 743B.005, shall provide coverage for all colorectal cancer screening examinations and  
29 laboratory tests assigned either a grade of A or a grade of B by the United States Preventive Ser-  
30 vices Task Force.

31 (2) If an insured is 50 years of age or older, an insurer may not impose cost sharing on the  
32 coverage required by subsection (1) of this section and the coverage shall include, at a minimum:

33 (a)(A) Fecal occult blood tests;

34 (B) Colonoscopies, including the removal of polyps during a screening procedure; or

35 (C) Double contrast barium enemas; and

36 (b) A colonoscopy, including the removal of polyps during the procedure, if the insured has a  
37 positive result on any fecal test assigned either a grade of A or a grade of B by the United States  
38 Preventive Services Task Force.

39 (3) If an insured is at high risk for colorectal cancer, the coverage required by subsection (1)  
40 of this section shall include colorectal cancer screening examinations and laboratory tests as re-  
41 commended by the treating physician.

42 (4) For the purposes of subsection (3) of this section, an individual is at high risk for colorectal  
43 cancer if the individual has:

44 (a) A family medical history of colorectal cancer;

45 (b) A prior occurrence of cancer or precursor neoplastic polyps;

1 (c) A prior occurrence of a chronic digestive disease condition such as inflammatory bowel dis-  
 2 ease, Crohn’s disease or ulcerative colitis; or

3 (d) Other predisposing factors.

4 (5) Subsection (2)(b) of this section does not apply to a high deductible health plan described in  
 5 26 U.S.C. 223.

6 **SECTION 90.** ORS 743A.141, as amended by section 2, chapter 9, Oregon Laws 2018, is amended  
 7 to read:

8 743A.141. (1) As used in this section:

9 (a) “Hearing aid” means any nondisposable, wearable instrument or device designed to aid or  
 10 compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory  
 11 for the instrument or device, except batteries and cords.

12 (b) “Hearing assistive technology systems” means devices used with or without hearing aids or  
 13 cochlear implants to improve the ability of a user with hearing loss to hear in various listening  
 14 situations, such as being located a distance from a speaker, in an environment with competing  
 15 background noise or in a room with poor acoustics or reverberation.

16 (2) **Except as provided in section 5 of this 2019 Act**, a health benefit plan, as defined in ORS  
 17 743B.005, shall provide payment, coverage or reimbursement for:

18 (a) One hearing aid per hearing impaired ear if:

19 (A) Prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed  
 20 physician; and

21 (B) Medically necessary for the treatment of hearing loss in an enrollee in the plan who is:

22 (i) 18 years of age or younger; or

23 (ii) 19 to 25 years of age and enrolled in a secondary school or an accredited educational insti-  
 24 tution.

25 (b) Ear molds and replacement ear molds:

26 (A) Up to four times per plan year for enrollees who are younger than eight years of age; and

27 (B) At least once per year for enrollees who are:

28 (i) Eight to 18 years of age; or

29 (ii) 19 to 25 years of age and enrolled in a secondary school or an accredited educational insti-  
 30 tution.

31 (c) One box of replacement batteries per year for each hearing aid.

32 (d) Necessary diagnostic and treatment services at least twice per year for enrollees who are  
 33 younger than four years of age and at least once per year for enrollees who are four years of age  
 34 or older, including:

35 (A) Hearing tests appropriate for an enrollee’s age or developmental need;

36 (B) Hearing aid checks; and

37 (C) Aided testing.

38 (e) Bone conduction sound processors, if necessary for appropriate amplification of the hearing  
 39 loss.

40 (f) Hearing assistive technology systems for an enrollee who is younger than 19 years of age, if  
 41 necessary for appropriate amplification of the hearing loss.

42 (3) An insurer may not impose any financial or contractual penalty upon an audiologist if an  
 43 enrollee elects to purchase a hearing aid or other device priced higher than the benefit amount by  
 44 paying the difference between the benefit amount and the price of the hearing aid or other device.

45 (4) A health benefit plan shall provide the benefits described in subsection (2)(a), (e) and (f) of

1 this section:

2 (a) Every 36 months; or

3 (b) For hearing aids, more frequently than every 36 months if modifications to an existing  
4 hearing aid will not meet the needs of an enrollee who is:

5 (A) Under 19 years of age; or

6 (B) 19 to 25 years of age and enrolled in a secondary school or an accredited educational in-  
7 stitution.

8 (5) An insurer must contract with pediatric audiologists in sufficient numbers and geographic  
9 locations in this state to comply with ORS 743B.202 and 743B.505.

10 (6) Insurance producers shall ensure that enrollees have access to navigators or other assisters  
11 to facilitate the diagnosis of hearing loss and needed amplification and ensure that technologies are  
12 available to treat hearing loss in enrollees who are 19 years of age or younger. Upon receiving a  
13 claim for reimbursement for the diagnosis of hearing loss, an insurer shall provide notice of the  
14 coverage limits to the enrollee or to the parent or legal guardian of the enrollee. With respect to  
15 enrollees with hearing loss who are younger than 19 years of age, an insurer shall provide educa-  
16 tional materials to the parent or legal guardian of the enrollee and shall have a process in place to  
17 ensure that appropriate technologies are available.

18 (7) The payment, coverage or reimbursement required under this section may be subject to  
19 provisions of the health benefit plan that apply to other durable medical equipment benefits covered  
20 by the plan, including but not limited to provisions relating to deductibles, coinsurance and prior  
21 authorization.

22 (8) This section is exempt from ORS 743A.001.

23 **SECTION 91.** ORS 743A.148 is amended to read:

24 743A.148. (1) The Legislative Assembly declares that all group health insurance policies pro-  
25 viding hospital, medical or surgical expense benefits, other than limited benefit coverage, include  
26 coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment **unless**  
27 **the coverage is available through the Health Care for All Oregon Plan.**

28 (2) As used in this section, “maxillofacial prosthetic services considered necessary for adjunctive  
29 treatment” means restoration and management of head and facial structures that cannot be replaced  
30 with living tissue and that are defective because of disease, trauma or birth and developmental  
31 deformities when such restoration and management are performed for the purpose of:

32 (a) Controlling or eliminating infection;

33 (b) Controlling or eliminating pain; or

34 (c) Restoring facial configuration or functions such as speech, swallowing or chewing but not  
35 including cosmetic procedures rendered to improve on the normal range of conditions.

36 (3) The coverage required by subsection (1) of this section may be made subject to provisions  
37 of the policy that apply to other benefits under the policy including, but not limited to, provisions  
38 relating to deductibles and coinsurance.

39 (4) The services described in this section shall apply to individual health policies entered into  
40 or renewed on or after January 1, 1982.

41 **SECTION 92.** ORS 743A.160 is amended to read:

42 743A.160. **Except as provided in section 5 of this 2019 Act,** a health insurance policy provid-  
43 ing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide, at  
44 the request of the applicant, coverage for expenses arising from treatment for alcoholism. The fol-  
45 lowing conditions apply to the requirement for such coverage:

1 (1) The applicant shall be informed of the applicant's option to request this coverage.

2 (2) The inclusion of the coverage may be made subject to the insurer's usual underwriting re-  
3 quirements.

4 (3) The coverage may be made subject to provisions of the policy that apply to other benefits  
5 under the policy, including but not limited to provisions relating to deductibles and coinsurance.

6 (4) The policy may limit hospital expense coverage to treatment provided by the following fa-  
7 cilities:

8 (a) A health care facility licensed as required by ORS 441.015.

9 (b) A health care facility accredited by the Joint Commission.

10 (5) Except as permitted by subsection (3) of this section, the policy may not limit payments  
11 thereunder for alcoholism to an amount less than \$4,500 in any 24-consecutive month period and the  
12 policy shall provide coverage, within the limits of this subsection, of not less than 80 percent of the  
13 hospital and medical expenses for treatment for alcoholism.

14 **SECTION 93.** ORS 743A.168 is amended to read:

15 743A.168. (1) As used in this section:

16 (a) "Behavioral health assessment" means an evaluation by a provider, in person or using tele-  
17 medicine, to determine a patient's need for behavioral health treatment.

18 (b) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability  
19 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-  
20 partment or admission to a hospital to prevent a serious deterioration in the individual's mental or  
21 physical health.

22 (c) "Chemical dependency" means the addictive relationship with any drug or alcohol charac-  
23 terized by a physical or psychological relationship, or both, that interferes on a recurring basis with  
24 the individual's social, psychological or physical adjustment to common problems. For purposes of  
25 this section, "chemical dependency" does not include addiction to, or dependency on, tobacco, to-  
26 bacco products or foods.

27 (d) "Facility" means a corporate or governmental entity or other provider of services for the  
28 treatment of chemical dependency or for the treatment of mental or nervous conditions.

29 (e) "Group health insurer" means an insurer, a health maintenance organization or a health care  
30 service contractor.

31 (f) "Program" means a particular type or level of service that is organizationally distinct within  
32 a facility.

33 (g) "Provider" means:

34 (A) An individual who has met the credentialing requirement of a group health insurer, is oth-  
35 erwise eligible to receive reimbursement for coverage under the policy and is a behavioral health  
36 professional or a medical professional licensed or certified in this state;

37 (B) A health care facility as defined in ORS 433.060;

38 (C) A residential facility as defined in ORS 430.010;

39 (D) A day or partial hospitalization program;

40 (E) An outpatient service as defined in ORS 430.010; or

41 (F) A provider organization certified by the Oregon Health Authority under subsection (7) of this  
42 section.

43 (2) **Except as provided in section 5 of this 2019 Act**, a group health insurance policy provid-  
44 ing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide  
45 coverage for expenses arising from the diagnosis of and treatment for chemical dependency, includ-

1 ing alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations  
2 no more restrictive than, those imposed on coverage or reimbursement of expenses arising from  
3 treatment for other medical conditions. The following apply to coverage for chemical dependency  
4 and for mental or nervous conditions:

5 (a) The coverage may be made subject to provisions of the policy that apply to other benefits  
6 under the policy, including but not limited to provisions relating to deductibles and coinsurance.  
7 Deductibles and coinsurance for treatment in health care facilities or residential facilities may not  
8 be greater than those under the policy for expenses of hospitalization in the treatment of other  
9 medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than  
10 those under the policy for expenses of outpatient treatment of other medical conditions.

11 (b) The coverage may not be made subject to treatment limitations, limits on total payments for  
12 treatment, limits on duration of treatment or financial requirements unless similar limitations or  
13 requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses  
14 may be limited to treatment that is medically necessary as determined under the policy for other  
15 medical conditions.

16 (c) The coverage must include:

17 (A) A behavioral health assessment;

18 (B) No less than the level of services determined to be medically necessary in a behavioral  
19 health assessment of a patient or in a patient's care plan:

20 (i) To treat the patient's behavioral health condition; and

21 (ii) For care following a behavioral health crisis, to transition the patient to a lower level of  
22 care; and

23 (C) Coordinated care and case management as defined by the Department of Consumer and  
24 Business Services by rule.

25 (d) A provider is eligible for reimbursement under this section if:

26 (A) The provider is approved or certified by the Oregon Health Authority;

27 (B) The provider is accredited for the particular level of care for which reimbursement is being  
28 requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities;

29 (C) The patient is staying overnight at the facility and is involved in a structured program at  
30 least eight hours per day, five days per week; or

31 (D) The provider is providing a covered benefit under the policy.

32 (e) If specified in the policy, outpatient coverage may include follow-up in-home service or out-  
33 patient services. The policy may limit coverage for in-home service to persons who are homebound  
34 under the care of a physician.

35 (f)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physi-  
36 cians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250  
37 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed profes-  
38 sional counselors and licensed marriage and family therapists, a group health insurer may provide  
39 for review for level of treatment of admissions and continued stays for treatment in health facilities,  
40 residential facilities, day or partial hospitalization programs and outpatient services by either group  
41 health insurer staff or personnel under contract to the group health insurer, or by a utilization re-  
42 view contractor, who shall have the authority to certify for or deny level of payment.

43 (B) Review shall be made according to criteria made available to providers in advance upon  
44 request.

45 (C) Review shall be performed by or under the direction of a physician licensed under ORS



1 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social  
2 worker licensed by the State Board of Licensed Social Workers or a professional counselor or mar-  
3 riage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and  
4 Therapists, in accordance with standards of the National Committee for Quality Assurance or  
5 Medicare review standards of the Centers for Medicare and Medicaid Services.

6 (D) Review may involve prior approval, concurrent review of the continuation of treatment,  
7 post-treatment review or any combination of these. However, if prior approval is required, provision  
8 shall be made to allow for payment of urgent or emergency admissions, subject to subsequent re-  
9 view. If prior approval is not required, group health insurers shall permit providers, policyholders  
10 or persons acting on their behalf to make advance inquiries regarding the appropriateness of a  
11 particular admission to a treatment program. Group health insurers shall provide a timely response  
12 to such inquiries. Noncontracting providers must cooperate with these procedures to the same ex-  
13 tent as contracting providers to be eligible for reimbursement.

14 (g) Health maintenance organizations may limit the receipt of covered services by enrollees to  
15 services provided by or upon referral by providers contracting with the health maintenance organ-  
16 ization. Health maintenance organizations and health care service contractors may create substan-  
17 tive plan benefit and reimbursement differentials at the same level as, and subject to limitations no  
18 more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other  
19 medical conditions and apply them to contracting and noncontracting providers.

20 (3) This section does not prohibit a group health insurer from managing the provision of benefits  
21 through common methods, including but not limited to selectively contracted panels, health plan  
22 benefit differential designs, preadmission screening, prior authorization of services, utilization re-  
23 view or other mechanisms designed to limit eligible expenses to those described in subsection (2)(b)  
24 of this section.

25 (4) The Legislative Assembly finds that health care cost containment is necessary and intends  
26 to encourage health insurance plans designed to achieve cost containment by ensuring that re-  
27 imbursement is limited to appropriate utilization under criteria incorporated into the insurance, ei-  
28 ther directly or by reference.

29 (5) This section does not prevent a group health insurer from contracting with providers of  
30 health care services to furnish services to policyholders or certificate holders according to ORS  
31 743B.460 or 750.005, subject to the following conditions:

32 (a) A group health insurer is not required to contract with all providers that are eligible for  
33 reimbursement under this section.

34 (b) An insurer or health care service contractor shall, subject to subsection (2) of this section,  
35 pay benefits toward the covered charges of noncontracting providers of services for the treatment  
36 of chemical dependency or mental or nervous conditions. The insured shall, subject to subsection  
37 (2) of this section, have the right to use the services of a noncontracting provider of services for the  
38 treatment of chemical dependency or mental or nervous conditions, whether or not the services for  
39 chemical dependency or mental or nervous conditions are provided by contracting or noncontracting  
40 providers.

41 (6)(a) This section does not require coverage for:

42 (A) Educational or correctional services or sheltered living provided by a school or halfway  
43 house;

44 (B) A long-term residential mental health program that lasts longer than 45 days;

45 (C) Psychoanalysis or psychotherapy received as part of an educational or training program,

1 regardless of diagnosis or symptoms that may be present;

2 (D) A court-ordered sex offender treatment program; or

3 (E) Support groups.

4 (b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpa-  
5 tient services under the terms of the insured's policy while the insured is living temporarily in a  
6 sheltered living situation.

7 (7) The Oregon Health Authority shall establish a process for the certification of an organiza-  
8 tion described in subsection (1)(g)(F) of this section that:

9 (a) Is not otherwise subject to licensing or certification by the authority; and

10 (b) Does not contract with the authority, a subcontractor of the authority or a community  
11 mental health program.

12 (8) The Oregon Health Authority shall adopt by rule standards for the certification provided  
13 under subsection (7) of this section to ensure that a certified provider organization offers a distinct  
14 and specialized program for the treatment of mental or nervous conditions.

15 (9) The Oregon Health Authority may adopt by rule an application fee or a certification fee, or  
16 both, to be imposed on any provider organization that applies for certification under subsection (7)  
17 of this section. Any fees collected shall be paid into the Oregon Health Authority Fund established  
18 in ORS 413.101 and shall be used only for carrying out the provisions of subsection (7) of this sec-  
19 tion.

20 (10) The intent of the Legislative Assembly in adopting this section is to reserve benefits for  
21 different types of care to encourage cost effective care and to ensure continuing access to levels  
22 of care most appropriate for the insured's condition and progress. This section does not prohibit an  
23 insurer from requiring a provider organization certified by the Oregon Health Authority under sub-  
24 section (7) of this section to meet the insurer's credentialing requirements as a condition of entering  
25 into a contract.

26 (11) The Director of the Department of Consumer and Business Services and the Oregon Health  
27 Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section  
28 that are considered necessary for the proper administration of this section.

29 **SECTION 94.** ORS 743A.170 is amended to read:

30 743A.170. (1) **Except as provided in section 5 of this 2019 Act**, a health benefit plan as defined  
31 in ORS 743B.005 must provide payment, coverage or reimbursement of at least \$500 for a tobacco  
32 use cessation program for a person enrolled in the plan who is 15 years of age or older.

33 (2) As used in this section, "tobacco use cessation program" means a program recommended by  
34 a physician that follows the United States Public Health Service guidelines for tobacco use cessa-  
35 tion. "Tobacco use cessation program" includes education and medical treatment components de-  
36 signed to assist a person in ceasing the use of tobacco products.

37 (3) This section is exempt from ORS 743A.001.

38 **SECTION 95.** ORS 743A.175 is amended to read:

39 743A.175. (1) **Except as provided in section 5 of this 2019 Act**, a health benefit plan, as de-  
40 fined in ORS 743B.005, shall provide coverage of medically necessary therapy and services for the  
41 treatment of traumatic brain injury.

42 (2) This section is exempt from ORS 743A.001.

43 **SECTION 96.** ORS 743A.188 is amended to read:

44 743A.188. (1) **Except as provided in section 5 of this 2019 Act**, all individual and group health  
45 insurance policies providing coverage for hospital, medical or surgical expenses, other than coverage

1 limited to expenses from accidents or specific diseases, shall include coverage for treatment of in-  
2 born errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which  
3 medically standard methods of diagnosis, treatment and monitoring exist, including quantification  
4 of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage  
5 shall include expenses of diagnosing, monitoring and controlling the disorders by nutritional and  
6 medical assessment, including but not limited to clinical visits, biochemical analysis and medical  
7 foods used in the treatment of such disorders.

8 (2) As used in this section, “medical foods” means foods that are formulated to be consumed or  
9 administered enterally under the supervision of a physician, as defined in ORS 677.010, that are  
10 specifically processed or formulated to be deficient in one or more of the nutrients present in typical  
11 nutritional counterparts, that are for the medical and nutritional management of patients with lim-  
12 ited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other  
13 specific nutrient requirements as established by medical evaluation and that are essential to opti-  
14 mize growth, health and metabolic homeostasis.

15 (3) This section is exempt from ORS 743A.001.

16 **SECTION 97.** ORS 743A.190 is amended to read:

17 743A.190. (1) **Except as provided in section 5 of this 2019 Act**, a health benefit plan, as de-  
18 fined in ORS 743B.005, must cover for a child enrolled in the plan who is under 18 years of age and  
19 who has been diagnosed with a pervasive developmental disorder all medical services, including re-  
20 habilitation services, that are medically necessary and are otherwise covered under the plan.

21 (2) The coverage required under subsection (1) of this section, including rehabilitation services,  
22 may be made subject to other provisions of the health benefit plan that apply to covered services,  
23 including but not limited to:

- 24 (a) Deductibles, copayments or coinsurance;
- 25 (b) Prior authorization or utilization review requirements; or
- 26 (c) Treatment limitations regarding the number of visits or the duration of treatment.

27 (3) As used in this section:

28 (a) “Medically necessary” means in accordance with the definition of medical necessity that is  
29 specified in the policy, certificate or contract for the health benefit plan and that applies uniformly  
30 to all covered services under the health benefit plan.

31 (b) “Pervasive developmental disorder” means a neurological condition that includes autism  
32 spectrum disorder, developmental delay, developmental disability or mental retardation.

33 (c) “Rehabilitation services” means physical therapy, occupational therapy or speech therapy  
34 services to restore or improve function.

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

36 (5) The definition of “pervasive developmental disorder” is not intended to apply to coverage  
37 required under ORS 743A.168 or section 2, chapter 771, Oregon Laws 2013.

38 **SECTION 98.** ORS 743A.190, as amended by section 20, chapter 771, Oregon Laws 2013, is  
39 amended to read:

40 743A.190. (1) **Except as provided in section 5 of this 2019 Act**, a health benefit plan, as de-  
41 fined in ORS 743B.005, must cover for a child enrolled in the plan who is under 18 years of age and  
42 who has been diagnosed with a pervasive developmental disorder all medical services, including re-  
43 habilitation services, that are medically necessary and are otherwise covered under the plan.

44 (2) The coverage required under subsection (1) of this section, including rehabilitation services,  
45 may be made subject to other provisions of the health benefit plan that apply to covered services,

1 including but not limited to:

- 2 (a) Deductibles, copayments or coinsurance;
- 3 (b) Prior authorization or utilization review requirements; or
- 4 (c) Treatment limitations regarding the number of visits or the duration of treatment.

5 (3) As used in this section:

6 (a) "Medically necessary" means in accordance with the definition of medical necessity that is  
7 specified in the policy, certificate or contract for the health benefit plan and that applies uniformly  
8 to all covered services under the health benefit plan.

9 (b) "Pervasive developmental disorder" means a neurological condition that includes autism  
10 spectrum disorder, developmental delay, developmental disability or mental retardation.

11 (c) "Rehabilitation services" means physical therapy, occupational therapy or speech therapy  
12 services to restore or improve function.

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

14 (5) The definition of "pervasive developmental disorder" is not intended to apply to coverage  
15 required under ORS 743A.168.

16 **SECTION 99.** ORS 743A.192 is amended to read:

17 743A.192. (1) **Except as provided in section 5 of this 2019 Act**, a health benefit plan, as de-  
18 fined in ORS 743B.005:

19 (a) Shall provide coverage for the routine costs of the care of patients enrolled in and partic-  
20 ipating in approved clinical trials;

21 (b) May not exclude, limit or impose additional conditions on the coverage of the routine costs  
22 for items and services furnished in connection with participation in an approved clinical trial; and

23 (c) May not include provisions that discriminate against an individual on the basis of the  
24 individual's participation in an approved clinical trial.

25 (2) As used in this section, "routine costs":

26 (a) Means all medically necessary conventional care, items or services consistent with the cov-  
27 erage provided by the health benefit plan if typically provided to a patient who is not enrolled in  
28 a clinical trial.

29 (b) Does not include:

30 (A) The drug, device or service being tested in the approved clinical trial unless the drug, device  
31 or service would be covered for that indication by the health benefit plan if provided outside of an  
32 approved clinical trial;

33 (B) Items or services required solely for the provision of the drug device or service being tested  
34 in the clinical trial;

35 (C) Items or services required solely for the clinically appropriate monitoring of the drug, device  
36 or service being tested in the clinical trial;

37 (D) Items or services that are provided solely to satisfy data collection and analysis needs and  
38 that are not used in the direct clinical management of the patient;

39 (E) Items or services customarily provided by a clinical trial sponsor free of charge to any  
40 participant in the clinical trial; or

41 (F) Items or services that are not covered by the health benefit plan if provided outside of the  
42 clinical trial.

43 (3) As used in this section, "approved clinical trial" means a clinical trial that is:

44 (a) Funded by the National Institutes of Health, the Centers for Disease Control and Prevention,  
45 the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services,

1 the United States Department of Defense or the United States Department of Veterans Affairs;

2 (b) Supported by a center or cooperative group that is funded by the National Institutes of  
3 Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and  
4 Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense  
5 or the United States Department of Veterans Affairs;

6 (c) Conducted as an investigational new drug application, an investigational device exemption  
7 or a biologics license application subject to approval by the United States Food and Drug Adminis-  
8 tration; or

9 (d) Exempt by federal law from the requirement to submit an investigational new drug applica-  
10 tion to the United States Food and Drug Administration.

11 (4) The coverage required by this section may be subject to provisions of the health benefit plan  
12 that apply to other benefits within the same category, including but not limited to copayments,  
13 deductibles and coinsurance.

14 (5) An insurer that provides coverage required by this section is not, based upon that coverage,  
15 liable for any adverse effects of the approved clinical trial.

16 (6) This section is exempt from ORS 743A.001.

17 **SECTION 100.** ORS 743A.252 is amended to read:

18 743A.252. (1) As used in this section:

19 (a) “Child abuse medical assessment” has the meaning given that term in ORS 418.782.

20 (b) “Community assessment center” has the meaning given that term in ORS 418.782.

21 (c) “Health benefit plan” has the meaning given that term in ORS 743B.005.

22 (2) **Except as provided in section 5 of this 2019 Act**, a health benefit plan shall provide pay-  
23 ment to or reimburse a community assessment center for the services provided by the center:

24 (a) In conducting a child abuse medical assessment of a child enrolled in the plan; and

25 (b) That are related to the child abuse medical assessment including, but not limited to:

26 (A) A forensic interview; and

27 (B) Mental health treatment.

28 (3) The payment or reimbursement made in accordance with this section must be proportionate  
29 to the scope and intensity of the services provided by the community assessment center.

30 (4) This section is exempt from ORS 743A.001.

31 **SECTION 101.** ORS 743B.005 is amended to read:

32 743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and  
33 743B.128:

34 (1) “Actuarial certification” means a written statement by a member of the American Academy  
35 of Actuaries or other individual acceptable to the Director of the Department of Consumer and  
36 Business Services that a carrier is in compliance with the provisions of ORS 743B.012 based upon  
37 the person’s examination, including a review of the appropriate records and of the actuarial as-  
38 sumptions and methods used by the carrier in establishing premium rates for small employer health  
39 benefit plans.

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

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

- 1 (a) That is applied uniformly and without regard to any health status related factors to an  
 2 enrollee or late enrollee;
- 3 (b) That must expire before any coverage becomes effective under the plan for the enrollee or  
 4 late enrollee;
- 5 (c) During which no premium shall be charged to the enrollee or late enrollee; and
- 6 (d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs  
 7 concurrently with any eligibility waiting period under the plan.
- 8 (4) "Bona fide association" means an association that:
- 9 (a) Has been in active existence for at least five years;
- 10 (b) Has been formed and maintained in good faith for purposes other than obtaining insurance;
- 11 (c) Does not condition membership in the association on any factor relating to the health status  
 12 of an individual or the individual's dependent or employee;
- 13 (d) Makes health insurance coverage that is offered through the association available to all  
 14 members of the association regardless of the health status of the member or individuals who are  
 15 eligible for coverage through the member;
- 16 (e) Does not make health insurance coverage that is offered through the association available  
 17 other than in connection with a member of the association;
- 18 (f) Has a constitution and bylaws; and
- 19 (g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.
- 20 (5) "Carrier" means any person who provides health benefit plans in this state, including:
- 21 (a) A licensed insurance company;
- 22 (b) A health care service contractor;
- 23 (c) A health maintenance organization;
- 24 (d) An association or group of employers that provides benefits by means of a multiple employer  
 25 welfare arrangement and that:
- 26 (A) Is subject to ORS 750.301 to 750.341; or
- 27 (B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by  
 28 ORS 743B.010 to 743B.013; or
- 29 (e) Any other person or corporation responsible for the payment of benefits or provision of ser-  
 30 vices.
- 31 (6) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms  
 32 of the health benefit plan covering the employee.
- 33 (7) "Eligible employee" means an employee who is eligible for coverage under a group health  
 34 benefit plan.
- 35 (8) "Employee" means any individual employed by an employer.
- 36 (9) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible  
 37 for a group or individual health benefit plan who has enrolled for coverage under the terms of the  
 38 plan.
- 39 [(10) "Exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031,  
 40 18032, 18033 and 18041.]
- 41 [(11) (10) "Exclusion period" means a period during which specified treatments or services are  
 42 excluded from coverage.
- 43 [(12) (11) "Financial impairment" means that a carrier is not insolvent and is:
- 44 (a) Considered by the director to be potentially unable to fulfill its contractual obligations; or
- 45 (b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

1        [(13)(a)] **(12)(a)** “Geographic average rate” means the arithmetical average of the lowest pre-  
 2        mium and the corresponding highest premium to be charged by a carrier in a geographic area es-  
 3        tablished by the director for the carrier’s:

- 4        (A) Group health benefit plans offered to small employers; or
- 5        (B) Individual health benefit plans.

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

8        [(14)] **(13)** “Grandfathered health plan” has the meaning prescribed by rule by the United States  
 9        Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e)  
 10       that is in effect on January 1, 2017.

11       [(15)] **(14)** “Group eligibility waiting period” means, with respect to a group health benefit plan,  
 12       the period of employment or membership with the group that a prospective enrollee must complete  
 13       before plan coverage begins.

14       [(16)(a)] **(15)(a)** “Health benefit plan” means any:

- 15       (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;
- 16       (B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or
- 17       (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-  
 18       ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the  
 19       extent that the plan is subject to state regulation.

20       (b) “Health benefit plan” does not include:

- 21       (A) Coverage for accident only, specific disease or condition only, credit or disability income;
- 22       (B) Coverage of Medicare services pursuant to contracts with the federal government;
- 23       (C) Medicare supplement insurance policies;
- 24       (D) Coverage of TRICARE services pursuant to contracts with the federal government;
- 25       (E) Benefits delivered through a flexible spending arrangement established pursuant to section  
 26       125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition  
 27       to a group health benefit plan;
- 28       (F) Separately offered long term care insurance, including, but not limited to, coverage of nurs-  
 29       ing home care, home health care and community-based care;
- 30       (G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity in-  
 31       surance;
- 32       (H) Short term health insurance policies that are in effect for periods of three months or less,  
 33       including the term of a renewal of the policy;

34       (I) Dental only coverage;

35       (J) Vision only coverage;

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

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

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

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

42       (O) Any employee welfare benefit plan that is exempt from state regulation because of the fed-  
 43       eral Employee Retirement Income Security Act of 1974, as amended[.]; **or**

44       **(P) Coverage provided by the Health Care for All Oregon Plan.**

45       (c) For purposes of this subsection, renewal of a short term health insurance policy includes the

1 issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days  
2 after the expiration of a policy previously issued by the insurer to the policyholder.

3 [(17)] (16) "Individual health benefit plan" means a health benefit plan:

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

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

7 [(18)] (17) "Initial enrollment period" means a period of at least 30 days following commence-  
8 ment of the first eligibility period for an individual.

9 [(19)] (18) "Late enrollee" means an individual who enrolls in a group health benefit plan sub-  
10 sequent to the initial enrollment period during which the individual was eligible for coverage but  
11 declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

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

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

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

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

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

24 [(20)] (19) "Multiple employer welfare arrangement" means a multiple employer welfare ar-  
25 rangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974,  
26 as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

27 [(21)] (20) "Preexisting condition exclusion" means:

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

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

38 [(22)] (21) "Premium" includes insurance premiums or other fees charged for a health benefit  
39 plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees cov-  
40 ered by the plan.

41 [(23)] (22) "Rating period" means the 12-month calendar period for which premium rates estab-  
42 lished by a carrier are in effect, as determined by the carrier.

43 [(24)] (23) "Representative" does not include an insurance producer or an employee or author-  
44 ized representative of an insurance producer or carrier.

45 [(25)] (24) "Small employer" means an employer who employed an average of at least one but



1 not more than 50 full-time equivalent employees on business days during the preceding calendar year  
 2 and who employs at least one full-time equivalent employee on the first day of the plan year, de-  
 3 termined in accordance with a methodology prescribed by the Department of Consumer and Business  
 4 Services by rule.

5 **SECTION 102.** ORS 743B.010 is amended to read:

6 743B.010. (1) If an affiliated group of employers is treated as a single employer under section  
 7 414(b), (c), (m) or (o) of the Internal Revenue Code of 1986, a carrier may issue a single group health  
 8 benefit plan to the affiliated group on the basis of the number of employees in the affiliated group  
 9 if the group requests such coverage.

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

14 (3)[(a)] ORS 743B.010 to 743B.013 shall continue to apply to a health benefit plan issued [*outside*  
 15 *of the exchange*] to a small employer until the plan anniversary date following the date the employer  
 16 no longer meets the definition of a small employer.

17 [(b)] *ORS 743B.010 to 743B.013 shall continue to apply to an employer that receives coverage*  
 18 *through the exchange until the employer no longer receives coverage through the exchange and is no*  
 19 *longer a small employer.*]

20 **SECTION 103.** ORS 743B.020 is amended to read:

21 743B.020. (1) The Department of Consumer and Business Services shall adopt by rule a method  
 22 for determining whether:

23 (a) An employee is an eligible employee as defined in ORS 743B.005; and

24 (b) An employer is a small employer as defined in ORS 743B.005.

25 (2) The method adopted by the department under subsection (1) of this section must be consist-  
 26 ent with corresponding federal requirements [*for the Small Business Health Options Program as de-*  
 27 *defined in ORS 741.300*].

28 **SECTION 104.** ORS 743B.128 is amended to read:

29 743B.128. Notwithstanding ORS 743B.012, 743B.013 and 743B.105, a carrier is not required to  
 30 actively market:

31 (1) A health benefit plan sold only to a bona fide association, to groups that are not members  
 32 of the bona fide association;

33 (2) A grandfathered health plan, to a group or individual who is not eligible for coverage under  
 34 the plan;

35 (3) A group health benefit plan, to a group that is not eligible for coverage under the plan; **or**

36 [(4)] *A qualified health plan sold only through the health insurance exchange, to an individual or*  
 37 *group outside of the exchange; or]*

38 [(5)] (4) A policy of group health insurance that may be delivered or issued for delivery in this  
 39 state without the approval of the Director of the Department of Consumer and Business Services  
 40 under ORS 742.003 (1).

41 **SECTION 105.** ORS 743B.505 is amended to read:

42 743B.505. (1) An insurer offering a health benefit plan in this state that provides coverage to  
 43 individuals or to small employers, as defined in ORS 743B.005, through a specified network of health  
 44 care providers shall:

45 (a) Contract with or employ a network of providers that is sufficient in number, geographic

1 distribution and types of providers to ensure that all covered services under the health benefit plan,  
2 including mental health and substance abuse treatment, are accessible to enrollees without unrea-  
3 sonable delay.

4 *[(b)(A) With respect to health benefit plans offered through the health insurance exchange under*  
5 *ORS 741.310, contract with a sufficient number and geographic distribution of essential community*  
6 *providers, where available, to ensure reasonable and timely access to a broad range of essential com-*  
7 *munity providers for low-income, medically underserved individuals in the plan's service area in ac-*  
8 *cordance with the network adequacy standards established by the Department of Consumer and*  
9 *Business Services;]*

10 *[(B) If the health benefit plan offered through the health insurance exchange offers a majority of*  
11 *the covered services through physicians employed by the insurer or through a single contracted medical*  
12 *group, have a sufficient number and geographic distribution of employed or contracted providers and*  
13 *hospital facilities to ensure reasonable and timely access for low-income, medically underserved*  
14 *enrollees in the plan's service area, in accordance with network adequacy standards adopted by the*  
15 *Department of Consumer and Business Services; or]*

16 *[(C) With respect to health benefit plans offered outside of the health insurance exchange, contract*  
17 *with or employ a network of providers that is sufficient in number, geographic distribution and types*  
18 *of providers to ensure access to care by enrollees who reside in locations within the health benefit*  
19 *plan's service area that are designated by the Health Resources and Services Administration of the*  
20 *United States Department of Health and Human Services as health professional shortage areas or*  
21 *low-income zip codes.]*

22 *[(c)]* (b) Annually report to the Department of Consumer and Business Services, in the format  
23 prescribed by the department, the insurer's plan for ensuring that the network of providers for each  
24 health benefit plan meets the requirements of this section.

25 (2)(a) An insurer may not discriminate with respect to participation under a health benefit plan  
26 or coverage under the plan against any health care provider who is acting within the scope of the  
27 provider's license or certification in this state.

28 (b) This subsection does not require an insurer to contract with any health care provider who  
29 is willing to abide by the insurer's terms and conditions for participation established by the insurer.

30 (c) This subsection does not prevent an insurer from establishing varying reimbursement rates  
31 based on quality or performance measures.

32 (d) Rules adopted by the Department of Consumer and Business Services to implement this sec-  
33 tion shall be consistent with the provisions of 42 U.S.C. 300gg-5 and the rules adopted by the United  
34 States Department of Health and Human Services, the United States Department of the Treasury  
35 or the United States Department of Labor to carry out 42 U.S.C. 300gg-5 that are in effect on Jan-  
36 uary 1, 2017.

37 (3) The Department of Consumer and Business Services shall use one of the following methods  
38 in evaluating whether the network of providers available to enrollees in a health benefit plan meets  
39 the requirements of this section:

40 (a) An approach by which an insurer submits evidence that the insurer is complying with at  
41 least one of the factors prescribed by the department by rule from each of the following categories:

42 (A) Access to care consistent with the needs of the enrollees served by the network;

43 (B) Consumer satisfaction;

44 (C) Transparency; and

45 (D) Quality of care and cost containment; or

1 (b) A nationally recognized standard adopted by the department and adjusted, as necessary, to  
2 reflect the age demographics of the enrollees in the plan.

3 (4) This section does not require an insurer to contract with an essential community provider  
4 that refuses to accept the insurer's generally applicable payment rates for services covered by the  
5 plan.

6 (5) This section does not require an insurer to submit provider contracts to the department for  
7 review.

8 **SECTION 106.** ORS 750.055, as amended by section 9, chapter 7, Oregon Laws 2018, is amended  
9 to read:

10 750.055. (1) The following provisions apply to health care service contractors to the extent not  
11 inconsistent with the express provisions of ORS 750.005 to 750.095:

12 (a) ORS 705.137, 705.138 and 705.139.

13 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398  
14 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS  
15 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,  
16 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

17 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not  
18 including ORS 732.582.

19 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695  
20 to 733.780.

21 (e) ORS 734.014 to 734.440.

22 (f) ORS 735.600 to 735.650.

23 (g) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to  
24 742.542.

25 (h) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.019, 743.020, 743.022, 743.023,  
26 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,  
27 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650  
28 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

29 (i) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,  
30 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,  
31 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,  
32 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170,  
33 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260 and section 2,  
34 chapter 771, Oregon Laws 2013.

35 (j) ORS 743B.001, 743B.003 to 743B.127, 743B.128, [743B.130,] 743B.195 to 743B.204, 743B.220,  
36 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257,  
37 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340,  
38 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450,  
39 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602  
40 and 743B.800 and section 5, chapter 7, Oregon Laws 2018.

41 (k) The following provisions of ORS chapter 744:

42 (A) ORS 744.001 to 744.009, 744.011, 744.013, 744.014, 744.018, 744.022 to 744.033, 744.037, 744.052  
43 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

44 (B) ORS 744.605, 744.609, 744.619, 744.621, 744.626, 744.631, 744.635, 744.650, 744.655 and 744.665,  
45 relating to the regulation of insurance consultants; and

1 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

2 (L) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,  
3 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

4 (2) The following provisions of the Insurance Code apply to health care service contractors ex-  
5 cept in the case of group practice health maintenance organizations that are federally qualified  
6 pursuant to Title XIII of the Public Health Service Act:

7 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-  
8 ates an in-house drug outlet.

9 (b) ORS 743A.024, unless the patient is referred by a physician, physician assistant or nurse  
10 practitioner associated with a group practice health maintenance organization.

11 (3) For the purposes of this section, health care service contractors are insurers.

12 (4) Any for-profit health care service contractor organized under the laws of any other state that  
13 is not governed by the insurance laws of the other state is subject to all requirements of ORS  
14 chapter 732.

15 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-  
16 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

17 (b) A health care service contractor's classification as a domestic insurance company under  
18 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510  
19 to 734.710.

20 (6) The Director of the Department of Consumer and Business Services may, after notice and  
21 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025  
22 and 750.045 that are necessary for the proper administration of these provisions.

23 **SECTION 107.** ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section  
24 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59,  
25 Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws  
26 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section  
27 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter  
28 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, and section 10, chapter 7,  
29 Oregon Laws 2018, is amended to read:

30 750.055. (1) The following provisions apply to health care service contractors to the extent not  
31 inconsistent with the express provisions of ORS 750.005 to 750.095:

32 (a) ORS 705.137, 705.138 and 705.139.

33 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398  
34 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS  
35 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,  
36 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

37 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not  
38 including ORS 732.582.

39 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695  
40 to 733.780.

41 (e) ORS 734.014 to 734.440.

42 (f) ORS 735.600 to 735.650.

43 (g) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to  
44 742.542.

45 (h) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.019, 743.020, 743.022, 743.023,

1 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,  
 2 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650  
 3 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

4 (i) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,  
 5 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,  
 6 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,  
 7 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170,  
 8 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260.

9 (j) ORS 743B.001, 743B.003 to 743B.127, 743B.128, [743B.130,] 743B.195 to 743B.204, 743B.220,  
 10 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257,  
 11 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340,  
 12 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450,  
 13 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602  
 14 and 743B.800 and section 5, chapter 7, Oregon Laws 2018.

15 (k) The following provisions of ORS chapter 744:

16 (A) ORS 744.001 to 744.009, 744.011, 744.013, 744.014, 744.018, 744.022 to 744.033, 744.037, 744.052  
 17 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

18 (B) ORS 744.605, 744.609, 744.619, 744.621, 744.626, 744.631, 744.635, 744.650, 744.655 and 744.665,  
 19 relating to the regulation of insurance consultants; and

20 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

21 (L) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,  
 22 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

23 (2) The following provisions of the Insurance Code apply to health care service contractors ex-  
 24 cept in the case of group practice health maintenance organizations that are federally qualified  
 25 pursuant to Title XIII of the Public Health Service Act:

26 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-  
 27 ates an in-house drug outlet.

28 (b) ORS 743A.024, unless the patient is referred by a physician, physician assistant or nurse  
 29 practitioner associated with a group practice health maintenance organization.

30 (3) For the purposes of this section, health care service contractors are insurers.

31 (4) Any for-profit health care service contractor organized under the laws of any other state that  
 32 is not governed by the insurance laws of the other state is subject to all requirements of ORS  
 33 chapter 732.

34 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-  
 35 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

36 (b) A health care service contractor's classification as a domestic insurance company under  
 37 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510  
 38 to 734.710.

39 (6) The Director of the Department of Consumer and Business Services may, after notice and  
 40 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025  
 41 and 750.045 that are necessary for the proper administration of these provisions.

42 **SECTION 108.** Section 2, chapter 771, Oregon Laws 2013, as amended by section 9, chapter 674,  
 43 Oregon Laws 2015, is amended to read:

44 **Sec. 2.** (1) As used in this section and section 3a, chapter 771, Oregon Laws 2013:

45 (a)(A) "Applied behavior analysis" means the design, implementation and evaluation of environ-

1 mental modifications, using behavioral stimuli and consequences, to produce significant improvement  
 2 in human social behavior, including the use of direct observation, measurement and functional  
 3 analysis of the relationship between environment and behavior, that is provided by:

4 (i) A licensed health care professional as defined in [section 1 of this 2015 Act] **ORS 676.802**;

5 (ii) A behavior analyst or assistant behavior analyst licensed under [section 3 of this 2015 Act]  
 6 **ORS 676.810**; or

7 (iii) A behavior analysis interventionist registered under [section 4 of this 2015 Act] **ORS 676.815**  
 8 who receives ongoing training and supervision by a licensed behavior analyst, by a licensed assist-  
 9 ant behavior analyst or by a licensed health care professional.

10 (B) “Applied behavior analysis” does not mean psychological testing, neuropsychology,  
 11 psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy and long-term coun-  
 12 seling as treatment modalities.

13 (b) “Autism spectrum disorder” has the meaning given that term in the fifth edition of the Di-  
 14 agnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric  
 15 Association.

16 (c) “Diagnosis” means medically necessary assessment, evaluation or testing.

17 (d) “Health benefit plan” has the meaning given that term in ORS [743.730] **743B.005**.

18 (e) “Medically necessary” means in accordance with the definition of medical necessity that is  
 19 specified in the policy or certificate for the health benefit plan and that applies to all covered ser-  
 20 vices under the plan.

21 (f) “Treatment for autism spectrum disorder” includes applied behavior analysis for up to 25  
 22 hours per week and any other mental health or medical services identified in the individualized  
 23 treatment plan, as described in subsection (6) of this section.

24 (2) **Except as provided in section 5 of this 2019 Act**, a health benefit plan shall provide cov-  
 25 erage of:

26 (a) The screening for and diagnosis of autism spectrum disorder by a licensed neurologist,  
 27 pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience  
 28 or training in the diagnosis of autism spectrum disorder; and

29 (b) Medically necessary treatment for autism spectrum disorder and the management of care, for  
 30 an individual who begins treatment before nine years of age, subject to the requirements of this  
 31 section.

32 (3) This section does not require coverage for:

33 (a) Services provided by a family or household member;

34 (b) Services that are custodial in nature or that constitute marital, family, educational or  
 35 training services;

36 (c) Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or ad-  
 37 venture camps, social counseling, telemedicine, music therapy, neurofeedback, chelation or  
 38 hyperbaric chambers;

39 (d) Services provided under an individual education plan in accordance with the Individuals with  
 40 Disabilities Education Act, 20 U.S.C. 1400 et seq.;

41 (e) Services provided through community or social programs; or

42 (f) Services provided by the Department of Human Services or the Oregon Health Authority,  
 43 other than employee benefit plans offered by the department and the authority.

44 (4) An insurer may not terminate coverage or refuse to issue or renew coverage for an individ-  
 45 ual solely because the individual has received a diagnosis of autism spectrum disorder or has re-

1 ceived treatment for autism spectrum disorder.

2 (5) Coverage under this section may be subject to utilization controls that are reasonable in the  
3 context of individual determinations of medical necessity. An insurer may require:

4 (a) An autism spectrum disorder diagnosis by a professional described in subsection (2)(a) of this  
5 section if the original diagnosis was not made by a professional described in subsection (2)(a) of this  
6 section.

7 (b) Prior authorization for coverage of a maximum of 25 hours per week of applied behavior  
8 analysis recommended in an individualized treatment plan approved by a professional described in  
9 subsection (2)(a) of this section for an individual with autism spectrum disorder, as long as the  
10 insurer makes a prior authorization determination no later than 30 calendar days after receiving the  
11 request for prior authorization.

12 (6) If an individual is receiving applied behavior analysis, an insurer may require submission of  
13 an individualized treatment plan, which shall include all elements necessary for the insurer to ap-  
14 propriately determine coverage under the health benefit plan. The individualized treatment plan  
15 must be based on evidence-based screening criteria. An insurer may require an updated individual-  
16 ized treatment plan, not more than once every six months, that includes observed progress as of the  
17 date the updated plan was prepared, for the purpose of performing utilization review and medical  
18 management. The insurer may require the individualized treatment plan to be approved by a pro-  
19 fessional described in subsection (2)(a) of this section, and to include the:

20 (a) Diagnosis;

21 (b) Proposed treatment by type;

22 (c) Frequency and anticipated duration of treatment;

23 (d) Anticipated outcomes stated as goals, including specific cognitive, social, communicative,  
24 self-care and behavioral goals that are clearly stated, directly observed and continually measured  
25 and that address the characteristics of the autism spectrum disorder; and

26 (e) Signature of the treating provider.

27 (7)(a) Once coverage for applied behavior analysis has been approved, the coverage continues  
28 as long as:

29 (A) The individual continues to make progress toward the majority of the goals of the individ-  
30 ualized treatment plan; and

31 (B) Applied behavior analysis is medically necessary.

32 (b) An insurer may require periodic review of an individualized treatment plan, as described in  
33 subsection (6) of this section, and modification of the individualized treatment plan if the review  
34 shows that the individual receiving the treatment is not making substantial clinical progress toward  
35 the goals of the individualized treatment plan.

36 (8) Coverage under this section may be subject to requirements and limitations no more re-  
37 strictive than those imposed on coverage or reimbursement of expenses arising from the treatment  
38 of other medical conditions under the policy or certificate, including but not limited to:

39 (a) Requirements and limitations regarding in-network providers; and

40 (b) Provisions relating to deductibles, copayments and coinsurance.

41 (9) This section applies to coverage for up to 25 hours per week of applied behavior analysis for  
42 an individual if the coverage is first requested when the individual is under nine years of age. This  
43 section does not limit coverage for any services that are otherwise available to an individual under  
44 ORS 743A.168 or 743A.190, including but not limited to:

45 (a) Treatment for autism spectrum disorder other than applied behavior analysis or the services

1 described in subsection (3) of this section;

2 (b) Applied behavior analysis for more than 25 hours per week; or

3 (c) Applied behavior analysis for an individual if the coverage is first requested when the indi-  
4 vidual is nine years of age or older.

5 (10) Coverage under this section includes treatment for autism spectrum disorder provided in the  
6 individual's home or a licensed health care facility or, for treatment provided by a licensed health  
7 care professional as defined in [section 1 of this 2015 Act] **ORS 676.802** or a behavior analyst or  
8 assistant behavior analyst licensed under [section 3 of this 2015 Act] **ORS 676.810**, in a setting ap-  
9 proved by the health care professional, behavior analyst or assistant behavior analyst.

10 (11) An insurer that provides coverage of applied behavior analysis in accordance with a deci-  
11 sion of an independent review organization that was made prior to January 1, 2016, shall continue  
12 to provide coverage, subject to modifications made in accordance with subsection (7) of this section.

13 (12) ORS 743A.001 does not apply to this section.

14  
15 **APPROPRIATION**

16  
17 **SECTION 109. There is appropriated to the Health Care for All Oregon Board, for the**  
18 **biennium beginning July 1, 2019, out of the General Fund, the amount of \$1 for deposit in the**  
19 **Health Care for All Oregon Fund established under section 13 of this 2019 Act, to be used for**  
20 **the purposes of the Health Care for All Oregon Board and for administering the Health Care**  
21 **for All Oregon Plan.**

22  
23 **TRANSFER OF ENROLLEES**  
24 **FROM HEALTH INSURANCE EXCHANGE**  
25 **TO HEALTH CARE FOR ALL OREGON PLAN**

26  
27 **SECTION 110. (1) The Department of Consumer and Business Services and the Oregon**  
28 **Health Authority shall collaborate to ensure that enrollees in qualified health plans, as de-**  
29 **defined in ORS 741.300, and employees of small employers that have purchased qualified health**  
30 **plans through the Small Business Health Options Program, as defined in ORS 741.300, on**  
31 **December 31, 2021, are, without interruption in coverage, transferred to the Health Care for**  
32 **All Oregon Plan on the operative date specified in section 115 of this 2019 Act.**

33 **(2) The department and the authority may take any steps necessary prior to the opera-**  
34 **tive date specified in section 115 of this 2019 Act that are necessary to ensure that individ-**  
35 **uals described in subsection (1) of this section are enrolled in the Health Care for All Oregon**  
36 **Plan on the operative date specified in section 115 of this 2019 Act.**

37 **SECTION 111. The moneys in the Health Insurance Exchange Fund and the unexpended**  
38 **balances of amounts authorized to be expended by the Department of Consumer and Business**  
39 **Services for the biennium beginning July 1, 2021, from revenues dedicated, continuously ap-**  
40 **propriated or otherwise made available for the purpose of administering the health insurance**  
41 **exchange shall revert to the General Fund on the operative date specified in section 115 of**  
42 **this 2019 Act.**

43  
44 **REPEALS**



1       **SECTION 112.** Section 23 of this 2019 Act is repealed on January 2, 2024.

2       **SECTION 113.** ORS 243.142, 243.144, 243.877, 413.085, 442.325, 442.342, 442.344, 442.347,  
3 735.601, 735.604, 735.608, 735.611, 735.617, 741.001, 741.002, 741.003, 741.004, 741.008, 741.102,  
4 741.105, 741.220, 741.222, 741.300, 741.310, 741.340, 741.342, 741.381, 741.390, 741.400, 741.500,  
5 741.510, 741.520, 741.540, 741.800, 741.801, 741.802, 741.900, 743.826 and 743B.130 and section 36a,  
6 chapter 3, Oregon Laws 2015, are repealed.

7

8

**CAPTIONS**

9

10       **SECTION 114.** The unit captions used in this 2019 Act are provided only for the conven-  
11 ience of the reader and do not become part of the statutory law of this state or express any  
12 legislative intent in the enactment of this 2019 Act.

13

14

**OPERATIVE DATE**

15

16       **SECTION 115.** Sections 1, 4 to 6, 11, 12, 16 and 17 of this 2019 Act, the amendments to  
17 ORS 238.538, 243.105, 243.107, 243.125, 243.129, 243.135, 243.140, 243.160, 243.163, 243.185, 243.215,  
18 243.221, 243.275, 243.285, 243.860, 243.864, 243.866, 243.867, 243.868, 243.874, 243.886, 292.051,  
19 346.565, 352.237, 408.370, 408.380, 411.400, 411.402, 411.406, 413.011, 413.017, 413.032, 413.037,  
20 414.025, 414.115, 430.021, 430.315, 431.120, 441.025, 441.060, 441.065, 441.550, 441.710, 442.015,  
21 442.315, 442.362, 442.394, 442.396, 471.752, 479.210, 677.450, 731.036, 742.400, 743A.001, 743A.012,  
22 743A.063, 743A.067, 743A.070, 743A.080, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110,  
23 743A.124, 743A.141, 743A.148, 743A.160, 743A.168, 743A.170, 743A.175, 743A.188, 743A.190,  
24 743A.192, 743A.252, 743B.005, 743B.010, 743B.020, 743B.128, 743B.505 and 750.055 and section 2,  
25 chapter 771, Oregon Laws 2013, by sections 18 to 22 and 26 to 108 of this 2019 Act and the  
26 repeal of ORS 243.142, 243.144, 243.877, 413.085, 442.325, 442.342, 442.344, 442.347, 735.601,  
27 735.604, 735.608, 735.611, 735.617, 741.001, 741.002, 741.003, 741.004, 741.008, 741.102, 741.105,  
28 741.220, 741.222, 741.300, 741.310, 741.340, 741.342, 741.381, 741.390, 741.400, 741.500, 741.510,  
29 741.520, 741.540, 741.800, 741.801, 741.802, 741.900, 743.826 and 743B.130 and section 36a, chapter  
30 3, Oregon Laws 2015, by section 113 of this 2019 Act become operative on January 1, 2022.

31

32

**EMERGENCY CLAUSE**

33

34       **SECTION 116.** This 2019 Act being necessary for the immediate preservation of the public  
35 peace, health and safety, an emergency is declared to exist, and this 2019 Act takes effect  
36 on its passage.

37

