A-Engrossed
Senate Bill 27

Ordered by the Senate May 8
Including Senate Amendments dated May 8

Sponsored by Senators JOHNSON, BURDICK, COURTNEY, DECKERT, GORDLY, KRUSE, METSGER, MORRISETTE, MORSE, PROZANSKI, SCHRADER, WINTERS, Representatives BONAMICI, BOONE, BUCKLEY, CANNON, CLEM, COWAN, GREENLICK, JENSON, KOMP, KOTEK, ROSENBAUM, TOMEI; Senator WALKER (at the request of The Archimedes Movement)

SUMMARY

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

Creates [*Oregon Health Fund*] **Oregon Better Health Trust Fund** to pool state and federal expenditures for health care in Oregon and to finance treatment of defined set of essential health conditions for all Oregonians. Continuously appropriates moneys in fund to [*Oregon Health Plan Board*] **Oregon Better Health Board** for purpose of providing health services to all Oregon residents.

[*Creates Oregon Health Fund Board to manage Oregon Health Fund.*] **Establishes Oregon Better Health Design Board to develop blueprint for national reform and to create defined set of essential health conditions for which benefits should be provided. Establishes Oregon Better Health Design Fund and continuously appropriates moneys in fund to board for board purposes.** Requires board to establish certain subcommittees for specified purposes.

[*Restructures Health Services Commission and*] Imposes new criteria **on Health Services Commission** for developing prioritized list of health conditions.

[*Requires Governor, within 90 days of passage of Act, to request congressional approval to redirect federal moneys into Oregon Health Fund, contingent upon development of implementation plan by Oregon Health Fund Board. Requires Governor, upon approval of request, to submit implementation plan to next following regular session of Legislative Assembly for consideration.*]

Requires Governor to present plan developed by Oregon Better Health Design Board as legislative proposal to Legislative Assembly. Specifies components of proposal.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health; creating new provisions; amending ORS 414.720; appropriating money; and declaring an emergency.

Whereas the objective of our health care system is health, not just the financing and delivery of health care services; and

Whereas health is more than just the absence of physical and mental disease; it is the product of a number of factors, only one of which is access to our medical system; and

Whereas persons with disabilities and other ongoing conditions can also live long and healthy lives; and

Whereas we cannot achieve the objective of health unless all individuals have timely access to the effective treatment of a defined set of essential and effective health conditions; and

Whereas we cannot achieve the objective of health unless we invest not only in health care, but also in education, economic opportunity, housing, sustainable environmental stewardship and other areas that are important contributing factors to health; and

Whereas the escalating cost of health care is compromising our ability to invest in those other areas that contribute to the health of the population; and

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.

Whereas we cannot achieve our objective of health unless we can control costs in the health care system; and

Whereas we cannot control costs unless we:

(1) Develop effective strategies to empower individuals through education as well as financial incentives and disincentives to assume more personal responsibility for their own health status through the choices they make;

(2) Reevaluate the structure of our 50-year federal financing and eligibility system in light of the realities and circumstances of the 21st century and of what we want the system to achieve from the standpoint of the health of our population; and

(3) Rethink how we define a "benefit" and restructure the misaligned financial incentives and inefficient system through which health care is currently delivered; and

Whereas public resources are finite and therefore the public resources available for health care are also finite; and

Whereas finite resources require that explicit priorities be set through an open process, with public input, to determine what should and should not be financed with public resources; and

Whereas those with more disposable private income will always be able to purchase more health care than those who depend solely on public resources; and

Whereas the current health care system is unsustainable in large part because of outdated federal policies that reflect the realities of the last century instead of the realities of today and that are based on assumptions that are no longer valid; and

Whereas the ability of states to maintain the public's health is increasingly constrained by those federal policies that were built around "categories" rather than a commitment to ensure that all citizens have timely access to the effective treatment of essential health conditions; and

Whereas public subsidies of employer-sponsored health coverage under the Tax Reform Act of 1954, Medicaid and Medicare, which were established through three specific acts of Congress in the last century, were enacted separately at different times for different reasons and reflect no sense of common purpose; and

Whereas the economic and demographic environment in which those federal programs were created has changed dramatically over the past 50 years, while the programs themselves continue to reflect a set of circumstances that existed in the mid-20th century; and

Whereas any reform effort that fails to address the contradictions and inequities embodied in the federal programs and fails to bring them into alignment with the realities of the 21st century will also fail to achieve meaningful reform, perpetuating the status quo and the contradictions, inequities and consequences existing in the current system; and

Whereas any strategies for financing, mandating or developing new programs to expand access must address what will be covered by public resources and how those services will be delivered, otherwise those strategies will do little to stem escalating medical costs, make health care more affordable or create a sustainable system; and

Whereas Oregon must take immediate action to develop, for consideration by the United State Congress, a proposed alternative to the way public dollars are currently being spent on health care within the state in order to create a sustainable system that will optimize the health of Oregonians; now, therefore,

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

SECTION 1. Sections 1 to 16 of this 2007 Act and ORS 414.720 shall be known as the Oregon Better Health Act.

SECTION 2. **It is the intent and the goal of the Legislative Assembly in enacting the Oregon Better Health Act to:**

(1) Ensure that all Oregonians have timely access to treatment for a defined set of essential health conditions;

(2) Offer a blueprint for national health care reform;

(3) Recognize that clinging to the system of employer-sponsored coverage as it is currently structured is not an option and to:

(a) Recognize that the current structure makes much less sense now than it did when the economic forces and incentives that created it were put in place over 50 years ago;

(b) Rethink the structure of the current system of employer-sponsored coverage in light of the realities of a highly competitive global economy, the increased mobility of the workforce and the changing structure of the workplace; and

(c) Develop a way to finance the treatment of a defined set of essential health conditions that are not tied to employment, relieving employers and employees of this cost while still leaving employers the option of offering secondary coverage designed to best serve the specific needs of their particular workforce;

(4) Recognize that clinging to the current structure of Medicaid, including the Medicaid health care benefit, is not an option and to:

(a) Eliminate the need for a special program for the poor by ensuring that all Oregonians, including the most vulnerable members of our society, have access to treatment for at least the same defined set of essential health conditions;

(b) Ensure that the medical and health needs of persons who are blind and persons with other disabilities and special needs are met in a timely and cost-effective manner with treatments that are physically and cognitively accessible and that produce quality outcomes; and

(c) Eliminate the complexity and administrative cost of assigning equally impoverished and vulnerable groups of Oregonians into dozens of different eligibility categories to determine how their care will be financed;

(5) Reconsider the current structure of the Medicare program, but not to dismantle it, and to:

(a) Recognize that clinging to the current structure of Medicare is not an option;

(b) Rethink the current structure of Medicare in light of the huge demographic trends and advances in medical technology that have taken place since Medicare was created in 1965;

(c) More rationally and honestly identify the medical and health needs of an aging population and to ensure that those needs are met in a timely and cost-effective manner with treatments that are physically and cognitively accessible and that produce quality outcomes; and

(d) Balance, in an equitable and sustainable manner, the medical and health needs of the elderly with those of the nonelderly and ensure that this balance is reflected in the allocation of public resources for health care; and

(6) Reconsider the workforce capacity in the current system in order to move to more effective and efficient delivery models that will produce quality outcomes.

SECTION 3. **The Oregon Better Health Act is based on the following principles:**

(1) Equity. All individuals must be eligible for and have timely access to treatment for

at least the same set of essential and effective health conditions.

(2) Financing. Financing of the health care system must be equitable, broadly based and affordable.

(3) Population benefit. The public must set priorities to optimize the health of Oregonians.

(4) Responsibility. Responsibility for optimizing health must be shared by individuals, employers, health systems and communities.

(5) Education. Education is a powerful tool for health promotion. The health care system must promote and engage in education activities for individuals, health systems and communities.

(6) Choice and dignity. Health care and health promotion systems must provide services in ways that support choice and dignity for individuals.

(7) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.

(8) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcomes.

(9) Explicit decision-making. Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.

(10) Transparency. The evidence used to support decisions must be clear, understandable and observable to the public.

(11) Economic sustainability. Health service expenditures must be managed to ensure sustainability over the long term, using efficient planning, budgeting and coordination of resources and reserves, based on public values that respect the inherent worth of all Oregonians and recognizing the impact that public and private health expenditures have on each other.

(12) Aligned financial incentives. Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Act.

(13) Wellness. Health and wellness promotion efforts must be emphasized and strengthened.

(14) Community-based. The delivery of care and distribution of resources must be organized to take place at the community level, unless outcomes or cost can be improved at regional or statewide levels.

(15) Coordination. Collaboration, coordination and integration of care and resources must be emphasized throughout the health system.

SECTION 4. (1) The Oregon Better Health Trust Fund is established separate and distinct from the General Fund. Interest earned from the investment of moneys in the Oregon Better Health Trust Fund shall be credited to the fund. The Oregon Better Health Trust Fund shall include, but is not limited to:

(a) State funds made available by the Legislative Assembly for purposes that are consistent with section 2 of this 2007 Act;

(b) Federal funds from Title XVVIII, XIX or XXI of the Social Security Act that may be made available to the fund by the federal government; and

(c) Contributions from any other source, public or private, transferred to the fund by the Legislative Assembly for the purpose of administering the Oregon Better Health Act.

(2) All moneys in the Oregon Better Health Trust Fund are continuously appropriated to the Oregon Better Health Board for the purpose of providing health services to all Oregon residents.

SECTION 5. (1) There is established the Oregon Better Health Design Board to develop a blueprint for national reform. The board shall consist of 11 members appointed by the Governor, subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution. The members of the board must include individuals with actuarial and financial management experience, individuals who are providers of health care and individuals who are consumers of health care, including seniors, people with disabilities and people with complex medical needs.

(2) The terms of the board members shall expire on July 1, 2009.

(3) If there is a vacancy for any cause, the Governor shall make an appointment to become effective immediately for the balance of the unexpired term.

(4) Members of the board are in the exempt service under ORS chapter 240, and the Governor shall fix their salaries in accordance with ORS 240.245.

(5) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(6) A majority of the members of the board constitutes a quorum for the transaction of business.

(7) Official action by the board requires the approval of a majority of the members of the board.

(8) The Oregon Better Health Design Fund is established separate and distinct from the General Fund. All moneys in the Oregon Better Health Design Fund are continuously appropriated to the Oregon Better Health Design Board for the purpose of carrying out the provisions of sections 5 to 15 of this 2007 Act.

SECTION 5a. The unexpended balances of amounts authorized to be expended by the Oregon Better Health Design Board for the biennium beginning July 1, 2007, from revenues dedicated, continuously appropriated, appropriated or otherwise made available for the purpose of administering and enforcing the duties, functions and powers under sections 5 to 15 of this 2007 Act, shall revert to the General Fund on June 30, 2009.

SECTION 6. (1) The Oregon Better Health Design Board shall appoint an executive director to serve at the pleasure of the board.

(2) The designation of the executive director must be by written order filed with the Secretary of State.

(3) Subject to any applicable provisions of ORS chapter 240, the executive director is authorized to hire, supervise and terminate the employees of the board, prescribe their duties and fix their compensation.

SECTION 7. The Oregon Better Health Design Board shall:

(1) Develop a plan to ensure that all Oregonians have access to treatment for a defined set of essential health conditions;

(2) Offer a proposal to implement the plan for consideration by the United States Congress as the basis for national health care reform;

(3) Oversee the actuarial process to create the defined set of essential health conditions in accordance with ORS 414.720 and section 10 of this 2007 Act; and

(4) Conduct public hearings to determine the adequacy of the defined set of essential health conditions in meeting the goals of the Oregon Better Health Act.

SECTION 8. In developing the plan described in section 14 of this 2007 Act, the Oregon Better Health Design Board shall make the following assumptions:

(1) The Oregon Better Health Board, described in section 13 of this 2007 Act, will enter into contracts with privately and publicly sponsored health care organizations for the treatment of the defined set of essential health conditions developed under ORS 414.720. The health care organizations shall include, but are not limited to, private health plans and insurers, health care service contractors, independent practice associations, managed care health services organizations, community clinics, community health centers, rural health clinics and federally qualified health centers.

(2) The contracts described in subsection (1) of this section will include standards for quality, performance and transparency, including transparency in costs, charges and outcomes.

(3) All Oregonians will be covered for the treatment of the same defined set of essential health conditions and the capitation rate must be the same for all contracting health care organizations.

(4) A health care provider or health care organization may not be subject to criminal prosecution, civil liability or professional disciplinary action for failing to provide a service that the Legislative Assembly does not fund or the Oregon Better Health Board has eliminated from coverage.

(5) The health care organizations will be community-rated and will compete with each other to enroll Oregonians on the basis of outcomes, service and the secondary coverage described in subsection (10) of this section.

(6) There will be no underwriting. Instead, each contract will contain a risk-adjusted formula.

(7) The Oregon Better Health Board will establish a minimum medical loss ratio for the health care organizations.

(8) The Oregon Better Health Board may create a high-risk pool spread over the entire population to help subsidize those health care organizations that assume more risk.

(9) Individuals will be permitted to choose their own health care organization and employers will be permitted to continue to serve as health insurance distributors for their employees.

(10) Health care organizations will be permitted to offer secondary coverage for services not included in the treatment of the defined set of essential health conditions, as long as they also offer coverage for the treatment of the defined set of essential health conditions. The secondary coverage must be separate and distinct from coverage for the treatment of the defined set of essential health conditions. The cost of secondary coverage purchased under this subsection may not be allowed as a deduction against state income taxes.

SECTION 9. In developing the plan described in section 14 of this 2007 Act, the Oregon Better Health Design Board shall:

(1) Encourage the use of information technology that is cost-neutral or has a positive return on investment, to deliver efficient, safe, quality care; and

(2) Implement a voluntary program to provide every Oregonian with a personal electronic health record. The personal electronic health record must be owned by the individual who

will control the use of and access to the information stored in it. The personal electronic health record must be portable and not tied to a health care organization, employer or governmental entity.

SECTION 10. (1) Within 60 days after the effective date of this 2007 Act, the Oregon Better Health Design Board shall begin the benefit design process, in accordance with ORS 414.720, to create the defined set of essential health conditions for which coverage will be provided. For the purposes of the benefit design process, the Oregon Better Health Design Board shall assume that the resources available to the Oregon Better Health Trust Fund will be the total of the following funds currently being spent on health care each year in Oregon:

(a) Medicare funds under Title XVIII of the Social Security Act, based on the national average for reimbursement rates;

(b) Medicaid funds under Title XIX of the Social Security Act used to fund the Oregon Health Plan, other medical services and administration;

(c) General Fund moneys that would otherwise be spent in the Medicaid program; and

(d) The value of state and federal tax expenditures for employer-sponsored health insurance coverage.

(2) The funds described in subsection (1) of this section do not include moneys currently spent on long term care services.

(3) The Oregon Better Health Design Board shall further assume that:

(a) If moneys accumulate in excess of the legislatively adopted budget for the Oregon Better Health Trust Fund during a biennium, the Oregon Better Health Board may authorize coverage for the treatment of additional health conditions from the list developed under ORS 414.720;

(b) If moneys in the Oregon Better Health Trust Fund are insufficient to provide coverage for the treatment of the defined set of essential health conditions to all eligible persons during a biennium, the number, types or categories of persons eligible for coverage will not be reduced by restricting eligibility requirements and the reimbursement rates for providers and health care organizations will not be reduced;

(c) In the circumstances described in paragraph (b) of this subsection, the Oregon Better Health Board, with the approval of the Legislative Assembly or Emergency Board and after two weeks′ notice to providers prior to any legislative consideration, may eliminate or modify coverage for treatment of the defined set of essential health conditions or request an additional General Fund appropriation or an amount from the reserve fund of the Emergency Board.

SECTION 11. Within 60 days after the effective date of this 2007 Act, the Oregon Better Health Design Board shall:

(1) Establish a subcommittee to develop options, using the criteria described in section 12 of this 2007 Act, for a collection mechanism to transfer the value of the public subsidy of employer-sponsored coverage through state and federal tax expenditures to the Oregon Better Health Trust Fund. The subcommittee must include both small and large business interests, including those offering coverage, those not offering coverage and those that are self-insured, employees of those businesses, including those belonging to Taft-Hartley trusts, and self-employed individuals;

(2) Establish a subcommittee to make recommendations on the most efficient and effec-

tive delivery system models producing quality outcomes for consideration in the actuarial process described in ORS 414.720 (6). The subcommittee must include, but not be limited to, primary care physicians, specialists, nurses, advanced practice nurses, mental health and chemical dependency treatment providers, dentists and providers from community health organizations, rural public health clinics, individuals with community-based health promotion and prevention programs and consumers of health care;

(3) Establish a subcommittee to make recommendations on how best to maximize the integration of health services with community-based long term care services to avoid disruptions in care. The subcommittee shall include, but is not limited to, providers of community-based long term care services, seniors, people with developmental disabilities, people with physical disabilities, people with chronic health conditions and people with complex medical needs.

(4) Establish a subcommittee to develop options to finance and implement the health information technology services and infrastructure described in section 9 of this 2007 Act;

(5) Establish a subcommittee to develop options to promote healthy behaviors through strategies that focus on both individual choices and environmental influences. These strategies shall include empowering individuals through education as well as financial incentives and disincentives to assume more responsibility for their own health status. Recognizing the powerful role that the social environment plays in health outcomes, the subcommittee also shall make recommendations regarding strategies to create environments that support, reinforce and enable health behaviors. The subcommittee shall include, but not be limited to, consumers of health care including seniors, people with disabilities and people with complex medical needs. The subcommittee shall consider the recommendations of the Health Services Commission concerning investments in nonclinical services and programs that have a bearing on the health of the population as required in ORS 414.720 (4)(e). The Oregon Better Health Design Board shall submit these options to an independent actuary to determine the costs of implementation and incorporate the costs into the plan developed under section 14 of this 2007 Act; and

(6) Establish a subcommittee to make recommendations concerning how to address the issue of medical liability including, but not limited to, a consideration of the implementation of a Medical Review Panel and a Patient's Compensation Fund, and providing liability protection for those health care organizations and providers that adhere to established best-practice standards and guidelines.

SECTION 12. The mechanism to transfer the value of the public subsidy of employer-sponsored coverage described in section 11 of this 2007 Act must:

(1) Not create an incentive for employers to discontinue coverage through the workplace;

(2) Address the inequities between employers that do and do not offer coverage;

(3) Recognize that small employers may have less margin with which to contribute to the cost of their employees' health care; and

(4) Take into account the global economy, the mobility of the workforce and the changing structure of the workplace.

SECTION 13. (1) The plan developed under section 14 of this 2007 Act shall include recommendations for the appointment of a permanent Oregon Better Health Board. The recommendations shall detail the structure, membership and responsibilities of the permanent board. The responsibilities of the board shall include, but are not limited to:

(a) Managing the Oregon Better Health Trust Fund;

(b) Overseeing the actuarial process, described in ORS 414.720, to define the set of essential health conditions;

(c) Conducting public hearings to determine the adequacy of the defined set of essential health conditions in meeting the goals of the Oregon Better Health Act described in section 2 of this 2007 Act; and

(d) Contracting with privately and publicly sponsored health care organizations in accordance with section 8 of this 2007 Act.

(2) The board shall be modeled after the Federal Reserve Board, to ensure the greatest amount of independence possible.

SECTION 14. (1) Based upon the recommendations of the subcommittees described in section 11 of this 2007 Act, the Oregon Better Health Design Board shall offer a plan to implement the goals and principles described in sections 2 and 3 of this 2007 Act. The plan shall detail:

(a) The administrative and governing structures of the new system on both the state and community levels;

(b) The structure of the delivery system, including standards for quality transparency and accountability as well as performance measures; and

(c) The actuarial process used to determine the cost of treating the defined set of essential health conditions to produce quality outcomes and to align the financial incentives in the system with the goals and principles of the Oregon Better Health Act.

(2) The board shall develop a transition plan that details the changes, resources and time frames necessary to make an orderly transition from the current system to the new system.

SECTION 15. In developing the plan under section 14 of this 2007 Act, the Oregon Better Health Design Board shall conduct public hearings and solicit testimony and information from advocates representing seniors, persons with disabilities, consumers of mental health services, low-income Oregonians, employers, employees, insurers and health plans and providers of health care including, but not limited to, primary care physicians, specialists, nurses, advanced practice nurses, mental health and chemical dependency treatment providers, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

SECTION 16. The Governor shall present the plan developed under section 14 of this 2007 Act as a legislative proposal to the regular or special session of the Legislative Assembly next following the Governor's approval of the plan. The legislative proposal shall:

(1) Request that the Oregon Congressional delegation sponsor federal legislation to support the plan; and

(2) Request federal authority to implement portions of the plan as pilot projects including, but not limited to:

(a) Medicare pilot projects that do not request state administration of Medicare funds but that do request waivers of Medicare laws by the Secretary of the United States Department of Health and Human Services; and

(b) Medicaid demonstration projects based on the plan and subject to approval of Medicaid waivers by the secretary.

SECTION 17. ORS 414.720 is amended to read:

414.720. (1) The Health Services Commission shall conduct public hearings prior to making the

report described in subsection (3) of this section. The commission shall solicit testimony and information from advocates representing seniors, persons with disabilities, mental health services consumers and low-income Oregonians, representatives of commercial carriers, representatives of small and large Oregon employers and providers of health care, including but not limited to physicians licensed to practice medicine, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

(2) The commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.

(3) Using a transparent process, the commission shall establish priorities from among health conditions, including physical, dental, vision, mental and chemical dependency, in 10 categories:

(a) Prevention;

(b) Pregnancy and childbirth;

(c) Acute life-threatening conditions;

(d) Acute non-life-threatening, self-limiting conditions;

(e) Catastrophic conditions;

(f) Chronic life-threatening conditions;

(g) Chronic non-life-threatening conditions;

(h) End of life;

(i) Rehabilitation; and

(j) Elective conditions.

(4) The commission shall establish priorities among the categories and within each category, from the most important to the least important, based upon the comparative health benefit of treating each condition for optimizing the health of the population and based on criteria that have been publicly debated and agreed upon by the Oregon Better Health Board, including, but not limited to:

(a) Social values;

(b) Clinical effectiveness of the treatment of the condition to produce quality outcomes;

(c) The degree to which medical evidence exists to support the relationship between the treatment and the desired quality health outcome;

(d) The relative cost-effectiveness of drugs, procedures and technologies in terms of the health benefit for the entire population served; and

(e) Investments needed in nonclinical services and programs that have a bearing on the health of the population.

[*(3)*] **(5) For the purpose of the benefit design process described in section 11 of this 2007 Act,** the commission shall report to the [*Governor a*] **Oregon Better Health Board the** list of health [*services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to*] **conditions ranked by priority from the most important to the least important based upon the comparative health benefit of treatment of each condition for optimizing the health of** the entire population to be served. The list submitted by the commission pursuant to this subsection is not subject to alteration by any other state agency. [*The recommendation may include practice guidelines reviewed and adopted by the commission pursuant to subsection (4) of this section.*]

[*(4) In order to encourage effective and efficient medical evaluation and treatment, the commission:*]

[*(a) May include clinical practice guidelines in its prioritized list of services. The commission shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical practice guidelines developed by the commission.*]

[*(b) Shall consider both the clinical effectiveness and cost-effectiveness of health services in determining their relative importance using peer-reviewed medical literature as defined in ORS 743.695.*]

[*(5) The commission shall make its report by July 1 of the year preceding each regular session of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Representatives and the President of the Senate.*]

[*(6) The commission may alter the list during interim only under the following conditions:*]

[*(a) Technical changes due to errors and omissions; and*]

[*(b) Changes due to advancements in medical technology or new data regarding health outcomes.*]

[*(7) If a service is deleted or added and no new funding is required, the commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the commission must report to the Emergency Board to request the funding.*]

[*(8) The report listing services to be provided pursuant to ORS 414.036, 414.042, 414.065, 414.107, 414.705 to 414.725 and 414.735 to 414.750 shall remain in effect from October 1 of the odd-numbered year through September 30 of the next odd-numbered year.*]

(6)(a) The Oregon Better Health Board shall be responsible for supervising an independent actuarial process to determine the cost of treating each condition on the list to produce quality outcomes.

(b) The board must develop the assumptions used in the actuarial process with the involvement and input of affected persons including, but not limited to, consumers of health care, employers, hospitals, primary care physicians, specialists, nurses, advanced practice nurses, mental health providers, dentists and providers from community health centers and rural health clinics.

(c) The board must base actuarial assumptions concerning utilization of services upon the most efficient and effective delivery system models producing quality outcomes, particularly for the management of chronic conditions.

(d) The actuarial assumptions developed by the board under paragraph (b) of this subsection must include the following:

(A) Providers must receive fair and reasonable payments that are stable and predictable for treating the covered set of essential health conditions to produce quality outcomes. Payments may include payment for other than in-person encounters.

(B) Payment levels must take into account the need to create incentives that ensure adequate provider capacity to meet the requirements of the most efficient and effective delivery system models producing quality outcomes.

(C) There must be value based cost-sharing for consumers, with lower or not cost sharing for the treatment of conditions that are higher on the priority list, particularly when the treatment is highly effective in producing quality outcomes, and with higher cost-sharing burdens for the treatment of elective, discretionary conditions and conditions that are lower on the priority list.

(7) The Oregon Better Health Board shall determine payment levels for the defined set of essential health conditions by:

(a) Dividing the Oregon Better Health Trust Fund by the eligible population to arrive at

a capitation rate, adjusted for population characteristics using standard actuarial principles; and

(b) Applying the capitation rate to the list described in subsection (5) of this section.

SECTION 18. Sections 5, 6 and 7 of this 2007 Act are repealed on July 1, 2009.

SECTION 19. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.