House Bill 2523

Sponsored by Representative MAURER, Senator KRUSE; Representatives FREEMAN, GILMAN, HANNA, OLSON, RICHARDSON, THOMPSON, WEIDNER, WHISNANT, Senators ATKINSON, BOQUIST

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 Oregon Health Access Fund and specifies permissible expenditures by Department of Human Services from fund. Continuously appropriates moneys in fund to department.

Creates Core Health Safety Net Integrity program in department to provide moneys to support health care safety net and community-based, patient-centered health care services to individuals facing barriers to accessing care.

Requires withholding amount from wages and salaries of eligible employees based on amount of employer contributions to benefit plans for which no employee contribution is required. Amount withheld is considered salary for purposes of retirement and pension benefits but is not taxable under state income tax or, as permitted by federal law, Social Security and federal income tax. Applies prospectively to collective bargaining agreements.

A BILL FOR AN ACT

Relating to health care; creating new provisions; amending ORS 414.725; appropriating money; and providing for revenue raising that requires approval by a three-fifths majority.

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

SECTION 1. (1) The Oregon Health Access Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Oregon Health Access Fund shall be credited to the fund. Moneys in the fund are continuously appropriated to the Department of Human Services for carrying out sections 1 and 2 of this 2009 Act.

(2) For each biennium, the department shall allocate moneys in the Oregon Health Access Fund as follows:

(a) Fifty percent to providing basic health and dental insurance to families who are categorically needy, as that term is defined in ORS 414.025;

(b) Twenty-five percent to increasing the rate of reimbursement for preventive health, dental and primary care services and funding innovative reimbursement models, including web-based office visits, telephone consultations and telemedicine consultations; and

(c) Twenty-five percent to:

(A) Maintaining or expanding access to medical and dental care through school-based health clinics and community health centers;

(B) Providing operational support for rural health centers that are not federally qualified health centers;

(C) Ensuring that rural health clinics are properly reimbursed as required by ORS 414.725 (1)(f); and

(D) Implementing the Core Health Safety Net Integrity program established in section 2 of this 2009 Act.

SECTION 2. (1) The Core Health Safety Net Integrity program is established in the Department of Human Services to assist in preserving the health care safety net and main-

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.

taining community-based, patient-centered health care services to individuals who face barriers to accessing care.

(2) The department shall expend moneys made available under section 1 of this 2009 Act for safety net clinics as necessary to enable the clinics to maintain essential services and to support the expansion of new clinics to medically underserved areas.

(3) The department shall establish priorities for expenditures under subsection (2) of this section based upon, but not limited to, the following factors:

(a) The financial difficulties faced by the safety net clinic;

(b) Whether the expenditure will maintain or expand essential comprehensive health services;

(c) Whether the expenditure will be used to establish new safety net clinics or to expand access to care in otherwise unserved or underserved geographical or specialty care areas;

(d) Whether the expenditure will improve the recruitment and retention of health care workers, including the expansion of the Rural Health Services Program created by ORS 442.555;

(e) Whether the expenditure is for the procurement and use of transformative technology;

(f) Whether the expenditure will reduce the cost of pharmaceuticals to consumers;

(g) Whether the expenditure will leverage nonstate funding; and

(h) Whether the expenditure will be used for technical assistance for purposes that are not directly linked to the immediate financial stability of a safety net clinic, such as for business planning or financial management.

SECTION 3. (1) As used in this section:

(a) "Benefit plan" means a life insurance contract or a health benefit plan covering medical, dental or vision benefits.

(b) "Eligible employee" has the meaning given that term in ORS 243.105.

(c) "Employer contribution" means the cost of the premium for a benefit plan if the cost is paid in full by the state without any payment by the eligible employee toward the cost.

(d) "Tier one employee" mean an eligible employee whose annual salary or wages are less than $31,000.

(e) "Tier two employee" means:

(A) An eligible employee whose annual salary or wages are equal to or greater than $31,000; or

(B) A member of the Legislative Assembly.

(2) For an eligible employee who is not required by a collective bargaining agreement to contribute toward the cost of a benefit plan covering the employee or a member of the employee's family, the payroll disbursing officer shall withhold monthly from the employee's salary or wages an amount calculated in accordance with subsection (4) of this section.

(3) The payroll disbursing officer shall pay the moneys withheld under this section to the Oregon Health Access Fund established in section 1 of this 2009 Act.

(4) The amount withheld monthly from an eligible employee's salary or wages under subsection (2) of this section shall be calculated based on the total employer contributions made for that month on behalf of the employee toward all benefit plans and shall equal:

(a) For each tier one employee:

(A) For the fiscal year beginning July 1, 2009, seven percent of the total employer con-

tributions made on behalf of the employee each month;

(B) For the fiscal year beginning July 1, 2010, nine percent of the total employer contributions made on behalf of the employee each month;

(C) For the fiscal year beginning July 1, 2011, 11 percent of the total employer contributions made on behalf of the employee each month; and

(D) For the fiscal year beginning July 1, 2012, and each fiscal year thereafter, 13 percent of the total employer contributions made on behalf of the employee each month.

(b) For each tier two employee:

(A) For the fiscal year beginning July 1, 2009, nine percent of the total employer contributions made on behalf of the employee each month;

(B) For the fiscal year beginning July 1, 2010, 11 percent of the total employer contributions made on behalf of the employee each month;

(C) For the fiscal year beginning July 1, 2011, 13 percent of the total employer contributions made on behalf of the employee each month; and

(D) For the fiscal year beginning July 1, 2012, and each fiscal year thereafter, 15 percent of the total employer contributions made on behalf of the employee each month.

(5) For each fiscal year beginning on or after July 1, 2009, the amount of salary or wages that defines tier one and tier two employees shall be adjusted by the percentage increase or decrease in the cost-of-living from the previous fiscal year based on the U.S. City Average Consumer Price Index for All Urban Consumers (All Items) as published by the Bureau of Labor Statistics of the United States Department of Labor.

(6) The amount withheld under this section from an eligible employee's salary or wages shall continue to be included as regular salary or wages for the purpose of computing the retirement and pension benefits earned by the employee, but that amount may not be considered current taxable income for the purpose of computing state income taxes withheld on behalf of the employee or, to the extent permitted by federal law, for the purpose of computing Social Security taxes or federal income taxes withheld on behalf of the employee.

SECTION 4. (1) For employees within a bargaining unit, section 3 of this 2009 Act applies to collective bargaining agreements entered into on or after the effective date of this 2009 Act.

(2) For all other employees, section 3 of this 2009 Act applies to payments of salary or wages that are made on or after a date that is one month after the effective date of this 2009 Act.

SECTION 5. ORS 414.725 is amended to read:

414.725. (1)(a) Pursuant to rules adopted by the Department of Human Services, the department shall execute prepaid managed care health services contracts for health services funded by the Legislative Assembly. The contract must require that all services are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. The contracts are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235. Notwithstanding ORS 414.720 (8), the rules adopted by the department shall establish timelines for executing the contracts described in this paragraph.

(b) It is the intent of ORS 414.705 to 414.750 that the state use, to the greatest extent possible, prepaid managed care health services organizations to provide physical health, dental, mental health and chemical dependency services under ORS 414.705 to 414.750.

(c) The department shall solicit qualified providers or plans to be reimbursed for providing the

covered services. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private prepaid managed care health services organization. The department may not discriminate against any contractors that offer services within their providers' lawful scopes of practice.

(d) The department shall establish annual financial reporting requirements for prepaid managed care health services organizations. The department shall prescribe a reporting procedure that elicits sufficiently detailed information for the department to assess the financial condition of each prepaid managed care health services organization and that includes information on the three highest executive salary and benefit packages of each prepaid managed care health services organization.

(e) The department shall require compliance with the provisions of paragraph (d) of this subsection as a condition of entering into a contract with a prepaid managed care health services organization.

(f)(A) A rural health clinic that receives a payment from a prepaid managed care health services organization for covered services provided to a person under ORS 414.705 to 414.750 may report the payment to the department in accordance with requirements adopted by the department by rule.

(B) The department shall prescribe by rule the timing, form and contents of the report described under subparagraph (A) of this paragraph.

(C) Within 45 days after receiving the report under this paragraph from a rural health clinic on a claim, or within 30 days after the last day of the calendar month of receipt of the report, whichever is later, the department shall issue a payment to the rural health clinic. The amount of the payment shall be the difference between the total amount paid to the rural health clinic from a prepaid managed care health services organization and other payors on a claim and the amount due from the department to the rural health clinic on the claim according to standards adopted by the department by rule.

(D) The department shall adopt by rule standards for the payment of claims for which the department is unable to determine the amount of the payment due under subparagraph (C) of this paragraph within the time frames specified in subparagraph (C) of this paragraph.

(E) "Rural health clinic," as used in this paragraph, shall be defined by the department by rule and shall be consistent with the definition of that term in 42 U.S.C. 1395x(aa)(2).

(2) The department may institute a fee-for-service case management system or a fee-for-service payment system for the same physical health, dental, mental health or chemical dependency services provided under the health services contracts for persons eligible for health services under ORS 414.705 to 414.750 in designated areas of the state in which a prepaid managed care health services organization is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee. In addition, the department may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the department for health services provided pursuant to ORS 414.705 to 414.750 may not exceed the total dollars appropriated for health services under ORS 414.705 to 414.750.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to

provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting to provide services under ORS 414.705 to 414.750 shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) A prepaid managed care health services organization shall provide information on contacting available providers to an enrollee in writing within 30 days of assignment to the health services organization.

(7) Each prepaid managed care health services organization shall provide upon the request of an enrollee or prospective enrollee annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

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

(8) A prepaid managed care health services organization may not limit enrollment in a designated area based on the zip code of an enrollee or prospective enrollee.

SECTION 6. The amendments to ORS 414.725 by section 5 of this 2009 Act apply to claims billed by a rural health clinic to a prepaid managed care health services organization on or after the effective date of this 2009 Act.