HOUSE AMENDMENTS TO HOUSE BILL 3418

By COMMITTEE ON RULES

May 24

On page 1 of the printed bill, line 2, delete "243.256" and insert "243.125, 243.256, 243.864, 243.879".

Delete lines 5 through 31.

On page 2, delete lines 1 through 4 and insert:

"**SECTION 1. (1) The Legislative Policy and Research Director, assisted by the advisory group described in subsection (3) of this section, shall conduct a comprehensive study and make recommendations to the Legislative Assembly regarding the reimbursement of prescription drugs in:**

"(a) The medical assistance program;

"(b) Public Employees' Benefit Board health benefit plans;

"(c) Oregon Educators Benefit Board health benefit plans; and

"(d) Other programs financed with state moneys that reimburse the cost of prescription drugs.

"(2) The director shall study the feasibility of:

"(a) Using a public utility model to monitor prescription drug prices in this state;

"(b) Implementing and maintaining a single preferred drug list to be used by coordinated care organizations and other medical assistance providers, the Public Employees' Benefit Board and the Oregon Educators Benefit Board;

"(c) An agency of state government acting as a pharmacy benefit manager to expand the purchasing power and negotiation leverage of the state in purchasing prescription drugs; and

"(d) Allowing Medicare Part D plans, coordinated care organizations, commercial insurers and other payers to participate in the Oregon Prescription Drug Program.

"(3) The director shall convene an advisory group to assist the director in carrying out the provisions of this section. The advisory group must include stakeholders or stakeholder representatives and staff of the Oregon Health Authority.

"(4) The director shall report the findings and recommendations under this section to the interim committees of the Legislative Assembly related to health no later than September 15, 2018.

"**SECTION 2.** ORS 243.256 is amended to read:

"243.256. [*(1) A hospital that provides services or supplies under a benefit plan offered by the Public Employees' Benefit Board shall be reimbursed using the methodology prescribed by the Oregon Health Authority under ORS 442.392 and may not be reimbursed for each service or supply provided.*]

"[*(2) This section applies to hospital payments made by a carrier under a contract with the board and to hospital payments made under a self-insurance program administered by a third party admin-*

istrator on behalf of the board.]

"**(1) A carrier that contracts with the Public Employees' Benefit Board to provide to eligible employees and their dependents a benefit plan that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:**

"(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

"(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

"(2) A self-insurance program administered by a third party administrator that is offered by the board to eligible employees and their dependents and that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

"(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

"(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

"(3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section may not charge to or collect from the patient or a person who is financially responsible for the patient an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other than cost sharing amounts authorized by the terms of the health benefit plan.

"(4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis, the payment method used must take into account the limits specified in subsections (1) and (2) of this section. Such payment methods include, but are not limited to:

"(a) Value-based payments;

"(b) Capitation payments; and

"(c) Bundled payments.

"[*(3)*] **(5)** This section does not apply to reimbursements paid by a carrier or third party administrator to [*a hospital that is not subject to the methodology prescribed by the authority under ORS 442.392.*]**:**

"(a) A type A or type B hospital as described in ORS 442.470; or

"(b) A rural critical access hospital as defined in ORS 315.613.

"(6) This section does not require a health benefit plan offered by the board to reimburse claims using a fee-for-service payment method.

"**SECTION 3.** ORS 243.125 is amended to read:

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

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

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

"(4)**(a)** The board shall prepare specifications, invite bids and do acts necessary to award contracts for health benefit plan and dental benefit plan coverage of eligible employees in accordance with the criteria set forth in ORS 243.135 (1).

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

"(5) The executive director of the board shall report to the Director of the Oregon Health Authority.

"(6) The board may retain consultants, brokers or other advisory personnel when necessary and, subject to the State Personnel Relations Law, shall employ such personnel as are required to perform the functions of the board.

"**SECTION 4.** ORS 243.879 is amended to read:

"243.879. [*(1) A hospital that provides services or supplies under a benefit plan offered by the Oregon Educators Benefit Board shall be reimbursed using the methodology prescribed by the Oregon Health Authority under ORS 442.392 and may not be reimbursed for each service or supply provided.*]

"[*(2) This section applies to hospital payments made by a carrier under a contract with the board and to hospital payments made under a self-insurance program administered by a third party administrator on behalf of the board.*]

"**(1) A carrier that contracts with the Oregon Educators Benefit Board to provide to eligible employees and their dependents a benefit plan that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:**

"(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

"(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

"(2) A self-insurance program administered by a third party administrator that is offered by the board to eligible employees and their dependents and that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

"(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

"(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

"(3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section

may not charge to or collect from the patient or a person who is financially responsible for the patient an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other than cost sharing amounts authorized by the terms of the health benefit plan.

"(4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis, the payment method used must take into account the limits specified in subsections (1) and (2) of this section. Such payment methods include, but are not limited to:

"(a) Value-based payments;

"(b) Capitation payments; and

"(c) Bundled payments.

"[*(3)*] **(5)** This section does not apply to reimbursements paid by a carrier or third party administrator to [*a hospital that is not subject to the methodology prescribed by the authority under ORS 442.392.*]**:**

"(a) A type A or type B hospital as described in ORS 442.470; or

"(b) A rural critical access hospital as defined in ORS 315.613.

"(6) This section does not require a health benefit plan offered by the board to reimburse claims using a fee-for-service payment method.

"**SECTION 5.** ORS 243.864 is amended to read:

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

"(a) Shall adopt rules for the conduct of its business and for carrying out ORS 243.879; and

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

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

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

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

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

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

"[*(5)*] **(6)** The board may retain consultants, brokers or other advisory personnel when necessary and shall employ such personnel as are required to perform the functions of the board.".

In line 5, delete "2" and insert "6".

Delete lines 11 and 12 and insert:

"**SECTION 7. (1) The amendments to ORS 243.125 and 243.256 by sections 2 and 3 of this**

2017 Act apply to health benefit plans offered by the Public Employees' Benefit Board on or after January 1, 2018.

"(2) The amendments to ORS 243.864 and 243.879 by sections 4 and 5 of this 2017 Act apply to health benefit plans offered by the Oregon Educators Benefit Board on or after October 1, 2018.

"**SECTION 8. Section 1 of this 2017 Act is repealed on December 31, 2018.**".

In line 13, delete "4" and insert "9".
