

DRAFT

SUMMARY

Requires Oregon Health Authority to provide biannual reports to committees of the Legislative Assembly related to health on issues related to financial requirements and financial reporting requirements imposed on coordinated care organizations.

Extends to November 1, 2021 deadline for Task Force on Universal Health Care to report findings and recommendations for Health Care for All Oregon Plan and Health Care for All Oregon Board.

Prohibits coordinated care organization from withholding information that must be reported to authority on ground that information is trade secret.

Prohibits authority from involuntarily transferring coordinated care organization member to another coordinated care organization prior to member's redetermination of eligibility for medical assistance. Specifies exceptions.

Exempts certain benefits required by law to be provided by health insurance from implied repeal by operation of law.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care; creating new provisions; amending ORS 414.591, 414.611 and 743A.001 and sections 8 and 10, chapter 629, Oregon Laws 2019; and declaring an emergency.

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

SECTION 1. (1) As used in this section, “coordinated care organization” has the meaning given that term in ORS 414.025.

(2) The Oregon Health Authority shall report to the committees of the Legislative Assembly related to health, in the manner provided in ORS 192.245, any of the following that occurred in the preceding six-

month period:

(a) Any civil penalty imposed on a coordinated care organization under ORS 414.591, 415.063 or 415.109 and the basis for the penalty;

(b) A description of any corrective action that the authority has required of a coordinated care organization based on ORS chapter 414, 415.056 or 415.063 and what steps were taken by the coordinated care organization;

(c) Any problems, financial concerns or other concerns raised by coordinated care organizations about financial reserve requirements imposed by the authority on coordinated care organizations under ORS 414.572 and how the authority addressed the problems or concerns; and

(d) Any concerns raised by coordinated care organizations about the use of National Association of Insurance Commissioners' reporting systems or any reporting required by the authority in addition to the National Association of Insurance Commissioners' standards.

(3) The authority shall provide the report described in subsection (2) every six months.

(4) With respect to the reporting of corrective actions under subsection (1)(b) of this section, if a coordinated care organization has not undertaken corrective action in time for the next report due, the authority shall report the action in the report due after the action is undertaken.

SECTION 2. The Oregon Health Authority shall first report the information described in section 1 of this 2020 Act no later than September 15, 2020.

SECTION 3. Section 8, chapter 629, Oregon Laws 2019, is amended to read:

Sec. 8. (1) The members of the Task Force on Universal Health Care shall be appointed no later than May 31, 2020.

(2) No later than September 30, 2020, the Legislative Policy and Research Office shall begin preparing a work plan for the task force.

(3)(a) The task force shall report to the committees of the Legislative Assembly related to health during the 2021 regular session of the Legislative Assembly on the progress in developing its findings and recommendations in accordance with section 6 (4), chapter 629, Oregon Laws 2019, and any work that remains and the timeline for completion of the work.

(b) No later than November 1, 2021, the task force shall submit a final report containing its findings and recommendations [*for the design of the Health Care for All Oregon Plan and the Health Care for All Oregon Board to the 2021 regular session of the Legislative Assembly*] in accordance with section 6 (4), chapter 629, Oregon Laws 2019, to the interim committees of the Legislative Assembly related to health.

SECTION 4. Section 10, chapter 629, Oregon Laws 2019, is amended to read:

Sec. 10. Sections 1 to 9 [*of this 2019 Act*], chapter 629, Oregon Laws 2019, are repealed on January 2, [2022] 2023.

SECTION 5. ORS 414.591 is amended to read:

414.591. (1) The Oregon Health Authority shall use, to the greatest extent possible, coordinated care organizations to provide fully integrated physical health services, chemical dependency and mental health services and oral health services. This section, and any contract entered into pursuant to this section, does not affect and may not alter the delivery of Medicaid-funded long term care services.

(2) The authority shall execute contracts with coordinated care organizations that meet the criteria adopted by the authority under ORS 414.572. Contracts under this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

(3)(a) The authority shall establish financial reporting requirements for coordinated care organizations, consistent with ORS 415.115 and 731.574, no less than 90 days before the beginning of the reporting period. The authority shall prescribe requirements and procedures for financial reporting that:

(A) Enable the authority to verify that the coordinated care organization's capital, surplus, reserves and other financial resources are adequate to ensure against the risk of insolvency;

(B) Include information on the three highest executive salary and benefit packages of each coordinated care organization;

(C) Require quarterly reports to be filed with the authority by May 31, August 31 and November 30;

(D) In addition to the annual audited financial statement required by ORS 415.115, require an annual report to be filed with the authority by April 30 following the end of the period for which data is reported; and

(E) Align, to the greatest extent practicable, with the National Association of Insurance Commissioners' reporting forms to reduce the administrative costs of coordinated care organizations that are also regulated by the Department of Consumer and Business Services or have affiliates that are regulated by the department.

(b) The authority shall provide information to coordinated care organizations about the reporting standards of the National Association of Insurance Commissioners and provide training on the reporting standards to the staff of coordinated care organizations who will be responsible for compiling the reports.

(c) A coordinated care organization may not withhold information required to be reported to the authority by ORS 414.593, 415.056, 415.115 or this section, or any other information required by statute or rule to be reported to the authority on the ground that the information is a trade secret as defined in ORS 192.345.

(4) The authority shall hold coordinated care organizations, contractors and providers accountable for timely submission of outcome and quality data, including but not limited to data described in ORS 442.373, prescribed by the authority by rule.

(5) The authority shall require compliance with the provisions of subsections (3) and (4) of this section as a condition of entering into a contract

1 with a coordinated care organization. A coordinated care organization, con-
2 tractor or provider that fails to comply with subsection (3) or (4) of this
3 section may be subject to sanctions, including but not limited to civil pen-
4 alties, barring any new enrollment in the coordinated care organization and
5 termination of the contract.

6 (6)(a) The authority shall adopt rules and procedures to ensure that if a
7 rural health clinic provides a health service to a member of a coordinated
8 care organization, and the rural health clinic is not participating in the
9 member's coordinated care organization, the rural health clinic receives total
10 aggregate payments from the member's coordinated care organization, other
11 payers on the claim and the authority that are no less than the amount the
12 rural health clinic would receive in the authority's fee-for-service payment
13 system. The authority shall issue a payment to the rural health clinic in
14 accordance with this subsection within 45 days of receipt by the authority
15 of a completed billing form.

16 (b) "Rural health clinic," as used in this subsection, shall be defined by
17 the authority by rule and shall conform, as far as practicable or applicable
18 in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

19 (7) The authority may contract with providers other than coordinated
20 care organizations to provide integrated and coordinated health care in areas
21 that are not served by a coordinated care organization or where the
22 organization's provider network is inadequate. Contracts authorized by this
23 subsection are not subject to ORS chapters 279A and 279B, except ORS
24 279A.250 to 279A.290 and 279B.235.

25 (8) The aggregate expenditures by the authority for health services pro-
26 vided pursuant to this chapter may not exceed the total dollars appropriated
27 for health services under this chapter.

28 (9) Actions taken by providers, potential providers, contractors and bid-
29 ders in specific accordance with this chapter in forming consortiums or in
30 otherwise entering into contracts to provide health care services shall be
31 performed pursuant to state supervision and shall be considered to be con-

ducted 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.

(10) Health care providers contracting to provide services under this chapter 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.

(11) A coordinated care organization shall provide information to a member as prescribed by the authority by rule, including but not limited to written information, within 30 days of enrollment with the coordinated care organization about available providers.

(12) Each coordinated care organization shall work to provide assistance that is culturally and linguistically appropriate to the needs of the member to access appropriate services and participate in processes affecting the member's care and services.

(13) Each coordinated care organization shall provide upon the request of a member or prospective member annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

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

(14) A coordinated care organization may not limit enrollment in a geographic area based on the zip code of a member or prospective member.

SECTION 6. ORS 414.611 is amended to read:

414.611. (1) The Oregon Health Authority may approve *[the]* **a coordinated care organization's request to** transfer *[of]* 500 or more members from one coordinated care organization to *[another]* **the requesting** coordinated care organization if:

(a) The members' provider has contracted with the *[receiving]* **requesting** organization and has stopped accepting patients from or has terminated providing services to members of the transferring organization; and

(b) Members are offered the choice of remaining members of the transferring organization.

(2) Members may not be transferred under this section until the authority has evaluated the *[receiving]* **requesting** organization and determined that the organization meets criteria established by the authority by rule, including but not limited to criteria that ensure that the organization meets the requirements of ORS 414.609 (1).

(3) The authority shall provide notice of a transfer under this section to members that will be affected by the transfer at least 90 days before the scheduled date of the transfer.

(4)(a) The authority may not approve the transfer of members under this section if:

(A) The transfer results from the termination of a provider's contract with a coordinated care organization for just cause; and

(B) The coordinated care organization has notified the authority that the provider's contract was terminated for just cause.

(b) A provider is entitled to a contested case hearing in accordance with ORS chapter 183, on an expedited basis, to dispute the denial of a transfer of members under this subsection.

(c) As used in this subsection, "just cause" means that the contract was terminated for reasons related to quality of care, competency, fraud or other similar reasons prescribed by the authority by rule.

(5) The provider and the organization shall be the parties to any contested case proceeding to determine whether the provider's contract was terminated for just cause **under subsection (4) of this section**. The authority may award attorney fees and costs to the party prevailing in the proceeding, applying the factors in ORS 20.075.

(6) The authority may not involuntarily transfer a member who is enrolled in a coordinated care organization serving the area where the member lives to any other coordinated care organization prior to the redetermination of the member's eligibility for medical assistance un-

der ORS 411.406 unless:

(a) The coordinated care organization is not in compliance with its contract with the authority; or

(b) The transfer is requested by the coordinated care organization in which the member is enrolled for good cause as prescribed by the authority by rule.

SECTION 7. ORS 743A.001 is amended to read:

743A.001. (1) Except as provided in subsection (4) of this section, any statute described in subsection (2) of this section that becomes effective on or after July 13, 1985, is repealed on the sixth anniversary of the effective date of the statute, unless the Legislative Assembly specifically provides otherwise.

(2) This section governs any statute that applies to individual or group health insurance policies and does any of the following:

(a) Requires the insurer to include coverage for specific physical or mental conditions or specific hospital, medical, surgical or dental health services.

(b) Requires the insurer to include coverage for specified persons.

(c) Requires the insurer to provide payment or reimbursement to specified providers of services if the services are within the lawful scope of practice of the provider and the insurance policy provides payment or reimbursement for those services.

(d) Requires the insurer to provide any specific coverage on a nondiscriminatory basis.

(e) Forbids the insurer to exclude from payment or reimbursement any covered services.

(f) Forbids the insurer to exclude coverage of a person because of that person's medical history.

(3) A repeal of a statute under subsection (1) of this section does not apply to any insurance policy in effect on the effective date of the repeal. However, the repeal of the statute applies to a renewal or extension of an existing insurance policy on or after the effective date of the repealer as well

1 as to a new policy issued on or after the effective date of the repealer.

2 (4) This section does not apply to ORS 743A.020, 743A.080, 743A.100,
3 743A.104, [and] 743A.108, **743A.124 and 743A.180, or any statute described**
4 **in subsection (2) of this section that requires coverage or reimburse-**
5 **ment of an essential health benefit.**

6 **SECTION 8. Section 1 of this 2020 Act is repealed on January 2, 2024.**

7 **SECTION 9. This 2020 Act being necessary for the immediate pres-**
8 **ervation of the public peace, health and safety, an emergency is de-**
9 **clared to exist, and this 2020 Act takes effect on its passage.**