House Bill 3075

Sponsored by Representatives SALINAS, GORSEK, WITT; Representatives BARKER, CLEM, DOHERTY, FINDLEY, GOMBERG, MITCHELL, PILUSO, REARDON, RESCHKE, SCHOUTEN, SMITH DB, SOLLMAN, WALLAN, Senators DEMBROW, FREDERICK, PROZANSKI, ROBLAN, WAGNER

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.**

Permits duplicate health benefit plan coverage for public employees.

Deletes provision requiring Oregon Educators Benefit Board to use payment methodologies in self-insured health benefit plans offered by board that are designed to limit growth in per-member expenditures for health services to no more than 3.4 percent per year.

Deletes provision requiring Oregon Educators Benefit Board to adopt policies and practices designed to limit annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.

Takes effect on 91st day following adjournment sine die.

1 **A BILL FOR AN ACT**

2 Relating to coverage of family members under state-sponsored health benefit plans; amending ORS
3 243.135 and 243.866; and prescribing an effective date.

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

5 **SECTION 1.** ORS 243.135, as amended by section 27, chapter 746, Oregon Laws 2017, is
6 amended to read:

7 243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
8 Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed
9 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
10 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
11 on:

12 (a) Employee choice among high quality plans;

13 (b) A competitive marketplace;

14 (c) Plan performance and information;

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

16 (e) Quality customer service;

17 (f) Creativity and innovation;

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

19 (h) The improvement of employee health; and

20 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
21 plan.

22 (2) The board may approve more than one carrier for each type of plan contracted for and of-
23 fered but the number of carriers shall be held to a number consistent with adequate service to eli-
24 gible employees and their family members.

25 (3) Where appropriate for a contracted and offered health benefit plan, the board shall provide
26 options under which an eligible employee may arrange coverage for family members [*who are not*
27 *enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board.*

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.

An eligible employee who declines coverage in a health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse or family member in another health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board may not be paid the employer contribution for the plan that was declined].

(4) Payroll deductions for costs that are not payable by the state or a local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

(5) In developing any 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) Transfer of enrollment from one 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) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) 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) By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care.

(11) No later than February 1 of each year, the board shall report to the Legislative Assembly 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 2. ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, and section 27, chapter 746, Oregon Laws 2017, is amended to read:

243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees, the state and the local governments. In considering whether to enter into a contract for a plan, the board shall place emphasis on:

(a) Employee choice among high quality plans;

(b) A competitive marketplace;

(c) Plan performance and information;

(d) Employer flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

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

(h) The improvement of employee health; and

(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan.

(2) The board may approve more than one carrier for each type of plan contracted for and offered but the number of carriers shall be held to a number consistent with adequate service to eligible employees and their family members.

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

(4) Payroll deductions for costs that are not payable by the state or a local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

(5) In developing any 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) Transfer of enrollment from one 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) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) 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 3. ORS 243.866, as amended by section 28, chapter 746, Oregon Laws 2017, is amended to read:

243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed to meet the needs and provide for the welfare of eligible employees, the districts and local governments. In considering whether to enter into a contract for a benefit plan, the board shall place emphasis on:

(a) Employee choice among high-quality plans;

(b) Encouragement of a competitive marketplace;

(c) Plan performance and information;

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

(e) Quality customer service;

(f) Creativity and innovation;

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

(h) Improvement of employee health; and

(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan.

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

(3) When appropriate, the board shall provide options under which an eligible employee may arrange coverage for family members under a benefit plan.

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

(5) In developing any benefit plan, the board may provide an option of additional coverage for eligible employees and family members at an additional premium.

(6) The board shall adopt rules providing that transfer of enrollment from one benefit plan to another is open to all eligible employees and family members. Because of the special problems that may arise involving acceptable provider-patient relations between a particular panel of providers and a particular eligible employee or family member under a comprehensive group practice benefit plan, the board shall provide a procedure under which any eligible employee may apply at any time to substitute another benefit plan for participation in a comprehensive group practice benefit plan.

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

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

[*(9)(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.*]

[*(10)*] **(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.

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

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

SECTION 4. ORS 243.866, as amended by section 17, chapter 489, Oregon Laws 2017, and section 28, chapter 746, Oregon Laws 2017, is amended to read:

243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed to meet the needs and provide for the welfare of eligible employees, the districts and local governments. In considering whether to enter into a contract for a benefit plan, the board shall place emphasis on:

(a) Employee choice among high-quality plans;

(b) Encouragement of a competitive marketplace;

(c) Plan performance and information;

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

(e) Quality customer service;

(f) Creativity and innovation;

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

(h) Improvement of employee health; and

(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan.

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

(3) When appropriate, the board shall provide options under which an eligible employee may arrange coverage for family members under a benefit plan.

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

(5) In developing any benefit plan, the board may provide an option of additional coverage for eligible employees and family members at an additional premium.

(6) The board shall adopt rules providing that transfer of enrollment from one benefit plan to

another is open to all eligible employees and family members. Because of the special problems that may arise involving acceptable provider-patient relations between a particular panel of providers and a particular eligible employee or family member under a comprehensive group practice benefit plan, the board shall provide a procedure under which any eligible employee may apply at any time to substitute another benefit plan for participation in a comprehensive group practice benefit plan.

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

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

[*(9)(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.*]

[*(10)*] **(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.

[*(11)*] **(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.

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

SECTION 5. This 2019 Act takes effect on the 91st day after the date on which the 2019 regular session of the Eightieth Legislative Assembly adjourns sine die.