

SENATE AMENDMENTS TO SENATE BILL 765

By COMMITTEE ON HEALTH CARE

April 15

1 On page 1 of the printed bill, line 2, after “243.105,” insert “243.107,” and after “243.866,” insert
2 “279A.025,”.

3 In line 3, delete “, 743.010 and 743.020” and insert “and 743.010” and after “2” insert “, 3”.

4 Delete lines 7 through 27 and delete pages 2 through 20.

5 On page 21, delete lines 1 through 35 and insert:

6 **“SECTION 2. (1) As used in this section:**

7 **“(a) ‘Behavioral health clinician’ means:**

8 **“(A) A psychiatrist;**

9 **“(B) A psychologist licensed under ORS 675.010 to 675.150;**

10 **“(C) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psy-**
11 **chiatric mental health;**

12 **“(D) A clinical social worker licensed under ORS 675.530;**

13 **“(E) A marriage and family therapist or professional counselor licensed under ORS**
14 **675.715;**

15 **“(F) A clinical social work associate certified under ORS 675.537; or**

16 **“(G) An intern or resident who is working under a board-approved supervisory contract**
17 **in a clinical mental health field.**

18 **“(b) ‘Primary care’ means family medicine, general internal medicine, naturopathic**
19 **medicine, pediatrics and care provided by primary care integrated behavioral health**
20 **clinicians or primary care integrated women’s health clinicians.**

21 **“(c) ‘Primary care integrated behavioral health clinician’ means:**

22 **“(A) A care team member as defined in ORS 414.025 (15)(b); or**

23 **“(B) A behavioral health clinician providing care to individuals and families in a patient**
24 **centered primary care home to address one or more of the following:**

25 **“(i) Mental illness.**

26 **“(ii) Substance use disorders.**

27 **“(iii) Health behaviors that contribute to chronic illness.**

28 **“(iv) Life stressors and crises.**

29 **“(v) Developmental risks and conditions.**

30 **“(vi) Stress-related physical symptoms.**

31 **“(vii) Preventive care.**

32 **“(viii) Ineffective patterns of health care utilization.**

33 **“(d) ‘Primary care integrated women’s health clinician’ means one of the following**
34 **clinicians whose practice is focused on women’s health and primary care and who provides**
35 **a range of the services within a patient centered primary care home:**

1 “(A) A physician who is an obstetrician or gynecologist;

2 “(B) A nurse practitioner;

3 “(C) A physician assistant; or

4 “(D) Another health professional licensed or certified in this state.

5 “(e) ‘Total medical expenditures’ means total expenditures for physical and mental health
6 care provided to members of a coordinated care organization, excluding expenditures for vi-
7 sion care and dental care.

8 “(2) No later than January 1, 2023, a coordinated care organization must spend at least
9 12 percent of the coordinated care organization’s total medical expenditures on primary care.

10 “(3) No later than January 1, 2020, a coordinated care organization must reimburse a
11 percentage, as established by the Oregon Health Authority by rule, of all primary care costs
12 using alternative payment methodologies.

13 “(4) After the Oregon Health Authority has established a global budget for a coordinated
14 care organization for a calendar year, the coordinated care organization shall report to the
15 authority, at the time and in the manner prescribed by the authority by rule:

16 “(a) The percentage of the global budget that the coordinated care organization antic-
17 ipates spending on primary care in the calendar year;

18 “(b) The percentage of the spending on primary care that will be in the form of alterna-
19 tive payment methodologies in the calendar year; and

20 “(c) The types of alternative payment methodologies that the coordinated care organiza-
21 tion will use during the calendar year.

22 “**SECTION 3.** ORS 243.105 is amended to read:

23 “243.105. As used in ORS 243.105 to 243.285, unless the context requires otherwise:

24 “(1) ‘Behavioral health clinician’ means:

25 “(a) A psychiatrist;

26 “(b) A psychologist licensed under ORS 675.010 to 675.150;

27 “(c) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psy-
28 chiatric mental health;

29 “(d) A clinical social worker licensed under ORS 675.530;

30 “(e) A marriage and family therapist or professional counselor licensed under ORS
31 675.715;

32 “(f) A clinical social work associate certified under ORS 675.537; or

33 “(g) An intern or resident who is working under a board-approved supervisory contract
34 in a clinical mental health field.

35 “[(1)] (2) ‘Benefit plan’ includes, but is not limited to:

36 “(a) Contracts for insurance or other benefits, including medical, dental, vision, life, disability
37 and other health care recognized by state law, and related services and supplies;

38 “(b) Comparable benefits for employees who rely on spiritual means of healing; and

39 “(c) Self-insurance programs managed by the Public Employees’ Benefit Board.

40 “[(2)] (3) ‘Board’ means the Public Employees’ Benefit Board.

41 “[(3)] (4) ‘Carrier’ means an insurance company or health care service contractor holding a valid
42 certificate of authority from the Director of the Department of Consumer and Business Services, or
43 two or more companies or contractors acting together pursuant to a joint venture, partnership or
44 other joint means of operation, or a board-approved guarantor of benefit plan coverage and com-
45 pensation.

1 “[(4)(a)] (5)(a) ‘Eligible employee’ means an officer or employee of a state agency or local gov-
2 ernment who elects to participate in one of the group benefit plans described in ORS 243.135. The
3 term includes, but is not limited to, state officers and employees in the exempt, unclassified and
4 classified service, and state officers and employees, whether or not retired, who:

5 “(A) Are receiving a service retirement allowance, a disability retirement allowance or a pen-
6 sion under the Public Employees Retirement System or are receiving a service retirement allowance,
7 a disability retirement allowance or a pension under any other retirement or disability benefit plan
8 or system offered by the State of Oregon for its officers and employees;

9 “(B) Are eligible to receive a service retirement allowance under the Public Employees Retire-
10 ment System and have reached earliest retirement age under ORS chapter 238;

11 “(C) Are eligible to receive a pension under ORS 238A.100 to 238A.250, and have reached ear-
12 liest retirement age as described in ORS 238A.165; or

13 “(D) Are eligible to receive a service retirement allowance or pension under another retirement
14 benefit plan or system offered by the State of Oregon and have attained earliest retirement age
15 under the plan or system.

16 “(b) ‘Eligible employee’ does not include individuals:

17 “(A) Engaged as independent contractors;

18 “(B) Whose periods of employment in emergency work are on an intermittent or irregular basis;

19 “(C) Who are employed on less than half-time basis unless the individuals are employed in po-
20 sitions classified as job-sharing positions, unless the individuals are defined as eligible under rules
21 of the board;

22 “(D) Appointed under ORS 240.309;

23 “(E) Provided sheltered employment or make-work by the state in an employment or industries
24 program maintained for the benefit of such individuals;

25 “(F) Provided student health care services in conjunction with their enrollment as students at
26 a public university listed in ORS 352.002; or

27 “(G) Who are members of a collective bargaining unit that represents police officers or fire-
28 fighters.

29 “[(5)] (6) ‘Family member’ means an eligible employee’s spouse and any unmarried child or
30 stepchild within age limits and other conditions imposed by the board with regard to unmarried
31 children or stepchildren.

32 “[(6)] (7) ‘Local government’ means any city, county or special district in this state or any
33 intergovernmental entity created under ORS chapter 190.

34 “(8) **‘Patient centered primary care home’ has the meaning given that term in ORS**
35 **414.025.**

36 “[(7)] (9) ‘Payroll disbursing officer’ means the officer or official authorized to disburse moneys
37 in payment of salaries and wages of employees of a state agency or local government.

38 “[(8)] (10) ‘Premium’ means the monthly or other periodic charge for a benefit plan.

39 “[(9)] (11) ‘Primary care’ means family medicine, general internal medicine, naturopathic medi-
40 cine, [*obstetrics and gynecology,*] pediatrics [*or general psychiatry.*] **and care provided by primary**
41 **care integrated behavioral health clinicians or primary care integrated women’s health**
42 **clinicians.**

43 “(12) **‘Primary care integrated behavioral health clinician’ means:**

44 “(a) **A care team member as defined in ORS 414.025 (15)(b); or**

45 “(b) **A behavioral health clinician providing care to individuals and families in a patient**

1 centered primary care home to address one or more of the following:

2 “(A) Mental illness.

3 “(B) Substance use disorders.

4 “(C) Health behaviors that contribute to chronic illness.

5 “(D) Life stressors and crises.

6 “(E) Developmental risks and conditions.

7 “(F) Stress-related physical symptoms.

8 “(G) Preventive care.

9 “(H) Ineffective patterns of health care utilization.

10 “(13) ‘Primary care integrated women’s health clinician’ means one of the following
11 clinicians whose practice is focused on women’s health and primary care and who provides
12 a range of the services within a patient centered primary care home:

13 “(a) A physician who is an obstetrician or gynecologist;

14 “(b) A nurse practitioner;

15 “(c) A physician assistant; or

16 “(d) Another health professional licensed or certified in this state.

17 “[10] (14) ‘State agency’ means every state officer, board, commission, department or other
18 activity of state government.

19 “[11] (15) ‘Total medical expenditures’ means payments to reimburse the cost of physical and
20 mental health care provided to eligible employees or their family members, excluding [*prescription*
21 *drugs,*] vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated
22 rate or other type of payment mechanism.

23 “**SECTION 3a.** ORS 243.107 is amended to read:

24 “243.107. A person employed by a public university listed in ORS 352.002 or the Oregon Health
25 and Science University may be considered an eligible employee for participation in one of the group
26 benefit plans described in ORS 243.135 if the governing board of the public university, or the Oregon
27 Health and Science University Board of Directors for Oregon Health and Science University em-
28 ployees, determines that funds are available therefor and if:

29 “(1) Notwithstanding ORS 243.105 [(4)(b)(F)] (5)(b)(F), the person is a student enrolled in an
30 institution of higher education and is employed as a graduate teaching assistant, graduate research
31 assistant or a fellow at the institution and elects to participate; or

32 “(2) Notwithstanding ORS 243.105 [(4)(b)(B)] (5)(b)(B) or (C), the person is employed on a less
33 than half-time basis in an unclassified instructional or research support capacity and elects to par-
34 ticipate.

35 “**SECTION 4.** ORS 243.135 is amended to read:

36 “243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
37 Employees’ Benefit Board, the board shall contract for a health benefit plan or plans best designed
38 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
39 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
40 on:

41 “(a) Employee choice among high quality plans;

42 “(b) A competitive marketplace;

43 “(c) Plan performance and information;

44 “(d) Employer flexibility in plan design and contracting;

45 “(e) Quality customer service;

1 “(f) Creativity and innovation;
2 “(g) Plan benefits as part of total employee compensation;
3 “(h) The improvement of employee health; and
4 “(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
5 plan.

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

9 “(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide
10 options under which an eligible employee may arrange coverage for family members.

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

14 “(5) In developing any health benefit plan, the board may provide an option of additional cov-
15 erage for eligible employees and their family members at an additional cost or premium.

16 “(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and
17 their family members under rules adopted by the board. Because of the special problems that may
18 arise in individual instances under comprehensive group practice plan coverage involving acceptable
19 provider-patient relations between a particular panel of providers and particular eligible employees
20 and their family members, the board shall provide a procedure under which any eligible employee
21 may apply at any time to substitute a health service benefit plan for participation in a comprehen-
22 sive group practice benefit plan.

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

25 “(8) By January 1, 2023, the board shall spend at least 12 percent of its total medical expen-
26 ditures in self-insured health benefit plans on payments for primary care.

27 “(9) **By January 1, 2020, the board shall reimburse a percentage, as established by rule**
28 **by the Oregon Health Authority in collaboration with the Department of Consumer and**
29 **Business Services, of all primary care costs in self-insured health benefit plans offered to**
30 **eligible employees using alternative payment methodologies, as defined in ORS 414.025.**

31 “(10) **No later than December 1 of each calendar year, the board shall report to the au-**
32 **thority, with respect to the self-insured health benefit plans offered to eligible employees for**
33 **the next calendar year:**

34 “(a) **The percentage of total medical expenditures that the board anticipates spending on**
35 **primary care;**

36 “(b) **The percentage of spending on primary care that will be in the form of alternative**
37 **payment methodologies; and**

38 “(c) **The types of alternative payment methodologies that will be used to reimburse**
39 **health care providers.**

40 “[9] (11) No later than February 1 of each year, the board shall report to the Legislative As-
41 sembly on the board’s progress toward achieving the [*target of spending at least 12 percent of total*
42 *medical expenditures in self-insured health benefit plans on payments for primary care*] **spending**
43 **targets described in subsection (8) of this section and the board’s plan for achieving the**
44 **targets.**

45 “**SECTION 5.** ORS 243.135, as amended by section 27, chapter 746, Oregon Laws 2017, is

1 amended to read:

2 “243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
3 Employees’ Benefit Board, the board shall contract for a health benefit plan or plans best designed
4 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
5 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
6 on:

7 “(a) Employee choice among high quality plans;

8 “(b) A competitive marketplace;

9 “(c) Plan performance and information;

10 “(d) Employer flexibility in plan design and contracting;

11 “(e) Quality customer service;

12 “(f) Creativity and innovation;

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

14 “(h) The improvement of employee health; and

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

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

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

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

31 “(5) In developing any health benefit plan, the board may provide an option of additional cov-
32 erage for eligible employees and their family members at an additional cost or premium.

33 “(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and
34 their family members under rules adopted by the board. Because of the special problems that may
35 arise in individual instances under comprehensive group practice plan coverage involving acceptable
36 provider-patient relations between a particular panel of providers and particular eligible employees
37 and their family members, the board shall provide a procedure under which any eligible employee
38 may apply at any time to substitute a health service benefit plan for participation in a comprehen-
39 sive group practice benefit plan.

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

42 “(8)(a) The board shall use payment methodologies in self-insured health benefit plans offered
43 by the board that are designed to limit the growth in per-member expenditures for health services
44 to no more than 3.4 percent per year.

45 “(b) The board shall adopt policies and practices designed to limit the annual increase in pre-

1 mium amounts paid for contracted health benefit plans to 3.4 percent.

2 “(9) A carrier or third party administrator that contracts with the board to provide or admin-
3 ister a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit
4 plan enrollees’ continued eligibility for coverage as spouses or dependents or any other basis that
5 would affect the cost of the premium for the plan.

6 “(10) By January 1, 2023, the board shall spend at least 12 percent of its total medical expen-
7 ditures in self-insured health benefit plans on payments for primary care.

8 **“(11) By January 1, 2020, the board shall reimburse a percentage, as established by rule
9 by the Oregon Health Authority in collaboration with the Department of Consumer and
10 Business Services, of all primary care costs in self-insured health benefit plans offered to
11 eligible employees using alternative payment methodologies, as defined in ORS 414.025.**

12 **“(12) No later than December 1 of each calendar year, the board shall report to the au-
13 thority, with respect to the self-insured health benefit plans offered to eligible employees for
14 the next calendar year:**

15 **“(a) The percentage of total medical expenditures that the board anticipates spending on
16 primary care;**

17 **“(b) The percentage of spending on primary care that will be in the form of alternative
18 payment methodologies; and**

19 **“(c) The types of alternative payment methodologies that will be used to reimburse
20 health care providers.**

21 **“[(11)] (13) No later than February 1 of each year, the board shall report to the Legislative
22 Assembly on the board’s progress toward achieving the [target of spending at least 12 percent of total
23 medical expenditures in self-insured health benefit plans on payments for primary care] spending
24 targets described in subsection (10) of this section and the board’s plan for achieving the
25 targets.**

26 **“SECTION 6.** ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, and
27 section 27, chapter 746, Oregon Laws 2017, is amended to read:

28 “243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
29 Employees’ Benefit Board, the board shall contract for a health benefit plan or plans best designed
30 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
31 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
32 on:

33 “(a) Employee choice among high quality plans;

34 “(b) A competitive marketplace;

35 “(c) Plan performance and information;

36 “(d) Employer flexibility in plan design and contracting;

37 “(e) Quality customer service;

38 “(f) Creativity and innovation;

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

40 “(h) The improvement of employee health; and

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

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

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

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

12 “(5) In developing any health benefit plan, the board may provide an option of additional cov-
13 erage for eligible employees and their family members at an additional cost or premium.

14 “(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and
15 their family members under rules adopted by the board. Because of the special problems that may
16 arise in individual instances under comprehensive group practice plan coverage involving acceptable
17 provider-patient relations between a particular panel of providers and particular eligible employees
18 and their family members, the board shall provide a procedure under which any eligible employee
19 may apply at any time to substitute a health service benefit plan for participation in a compre-
20 hensive group practice benefit plan.

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

23 “(8)(a) The board shall use payment methodologies in self-insured health benefit plans offered
24 by the board that are designed to limit the growth in per-member expenditures for health services
25 to no more than 3.4 percent per year.

26 “(b) The board shall adopt policies and practices designed to limit the annual increase in pre-
27 mium amounts paid for contracted health benefit plans to 3.4 percent.

28 “(9) A carrier or third party administrator that contracts with the board to provide or admin-
29 ister a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit
30 plan enrollees’ continued eligibility for coverage as spouses or dependents or any other basis that
31 would affect the cost of the premium for the plan.

32 **“(10) The board shall spend at least 12 percent of its total medical expenditures in self-
33 insured health benefit plans on payments for primary care.**

34 **“(11) The board shall reimburse a percentage, as established by rule by the Oregon Health
35 Authority in collaboration with the Department of Consumer and Business Services, of all
36 primary care costs in self-insured health benefit plans offered to eligible employees using
37 alternative payment methodologies, as defined in ORS 414.025.**

38 **“(12) No later than December 1 of each calendar year, the board shall report to the au-
39 thority, with respect to the self-insured health benefit plans offered to eligible employees for
40 the next calendar year:**

41 **“(a) The percentage of total medical expenditures that the board anticipates spending on
42 primary care;**

43 **“(b) The percentage of spending on primary care that will be in the form of alternative
44 payment methodologies; and**

45 **“(c) The types of alternative payment methodologies that will be used to reimburse**

1 **health care providers.**

2 “[*(10)*] **(13)** If the board [*spends less than 12 percent of its total medical expenditures in self-*
3 *insured health benefit plans on payments for primary care*] **fails to meet the financial requirements**
4 **described in subsection (10) of this section**, the board shall implement a plan for increasing, by
5 **at least one percent each year:**

6 “**(a)** The percentage of total medical expenditures spent on payments for primary care; **and**

7 “**(b)** **The percentage of primary care costs that are reimbursed using alternative payment**
8 **methodologies** [*by at least one percent each year*].

9 “[*(11)*] **(14)** No later than February 1 of each year, the board shall report to the Legislative
10 Assembly on any plan implemented under subsection [*(10)*] **(13)** of this section and on the board’s
11 progress toward achieving the [*target of spending at least 12 percent of total medical expenditures in*
12 *self-insured health benefit plans on payments for primary care*] **financial requirements described in**
13 **subsection (12) of this section.**

14 “**SECTION 7.** ORS 243.860 is amended to read:

15 “243.860. As used in ORS 243.860 to 243.886, unless the context requires otherwise:

16 “**(1) ‘Behavioral health clinician’ means:**

17 “**(a)** **A psychiatrist;**

18 “**(b)** **A psychologist licensed under ORS 675.010 to 675.150;**

19 “**(c)** **A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psy-**
20 **chiatric mental health;**

21 “**(d)** **A clinical social worker licensed under ORS 675.530;**

22 “**(e)** **A marriage and family therapist or professional counselor licensed under ORS**
23 **675.715;**

24 “**(f)** **A clinical social work associate certified under ORS 675.537; or**

25 “**(g)** **An intern or resident who is working under a board-approved supervisory contract**
26 **in a clinical mental health field.**

27 “[*(1)*] **(2)** ‘Benefit plan’ includes but is not limited to:

28 “(a) Contracts for insurance or other benefits, including medical, dental, vision, life, disability
29 and other health care recognized by state law, and related services and supplies;

30 “(b) Self-insurance programs managed by the Oregon Educators Benefit Board; and

31 “(c) Comparable benefits for employees who rely on spiritual means of healing.

32 “[*(2)*] **(3)** ‘Carrier’ means an insurance company or health care service contractor holding a valid
33 certificate of authority from the Director of the Department of Consumer and Business Services, or
34 two or more companies or contractors acting together pursuant to a joint venture, partnership or
35 other joint means of operation, or a board-approved provider or guarantor of benefit plan coverage
36 and compensation.

37 “[*(3)*] **(4)** ‘District’ means a common school district, a union high school district, an education
38 service district, as defined in ORS 334.003, or a community college district, as defined in ORS
39 341.005.

40 “[*(4)(a)*] **(5)(a)** ‘Eligible employee’ includes:

41 “(A) An officer or employee of a district or a local government who elects to participate in one
42 of the benefit plans described in ORS 243.864 to 243.874; and

43 “(B) An officer or employee of a district or a local government, whether or not retired, who:

44 “(i) Is receiving a service retirement allowance, a disability retirement allowance or a pension
45 under the Public Employees Retirement System or is receiving a service retirement allowance, a

1 disability retirement allowance or a pension under any other retirement or disability benefit plan
2 or system offered by the district or local government for its officers and employees;

3 “(ii) Is eligible to receive a service retirement allowance under the Public Employees Retirement
4 System and has reached earliest service retirement age under ORS chapter 238;

5 “(iii) Is eligible to receive a pension under ORS 238A.100 to 238A.250 and has reached earliest
6 retirement age as described in ORS 238A.165; or

7 “(iv) Is eligible to receive a service retirement allowance or pension under any other retirement
8 benefit plan or system offered by the district or local government and has attained earliest retire-
9 ment age under the plan or system.

10 “(b) Except as provided in paragraph (a)(B) of this subsection, ‘eligible employee’ does not in-
11 clude an individual:

12 “(A) Engaged as an independent contractor;

13 “(B) Whose periods of employment in emergency work are on an intermittent or irregular basis;
14 or

15 “(C) Who is employed on less than a half-time basis unless the individual is employed in a po-
16 sition classified as a job-sharing position or unless the individual is defined as eligible under rules
17 of the Oregon Educators Benefit Board or under a collective bargaining agreement.

18 “[5] (6) ‘Family member’ means an eligible employee’s spouse or domestic partner and any un-
19 married child or stepchild of an eligible employee within age limits and other conditions imposed
20 by the Oregon Educators Benefit Board with regard to unmarried children or stepchildren.

21 “[6] (7) ‘Local government’ means any city, county or special district in this state.

22 “(8) **‘Patient centered primary care home’ has the meaning given that term in ORS**
23 **414.025.**

24 “[7] (9) ‘Payroll disbursing officer’ means the officer or official authorized to disburse moneys
25 in payment of salaries and wages of officers and employees of a district or a local government.

26 “[8] (10) ‘Premium’ means the monthly or other periodic charge, including administrative fees
27 of the Oregon Educators Benefit Board, for a benefit plan.

28 “[9] (11) ‘Primary care’ means family medicine, general internal medicine, naturopathic medi-
29 cine, [*obstetrics and gynecology,*] pediatrics [*or general psychiatry.*] **and care provided by primary**
30 **care integrated behavioral health clinicians or primary care integrated women’s health**
31 **clinicians.**

32 **“(12) ‘Primary care integrated behavioral health clinician’ means:**

33 **“(a) A care team member as defined in ORS 414.025 (15)(b); or**

34 **“(b) A behavioral health clinician providing care to individuals and families in a patient**
35 **centered primary care home to address one or more of the following:**

36 **“(A) Mental illness.**

37 **“(B) Substance use disorders.**

38 **“(C) Health behaviors that contribute to chronic illness.**

39 **“(D) Life stressors and crises.**

40 **“(E) Developmental risks and conditions.**

41 **“(F) Stress-related physical symptoms.**

42 **“(G) Preventive care.**

43 **“(H) Ineffective patterns of health care utilization.**

44 **“(13) ‘Primary care integrated women’s health clinician’ means one of the following**
45 **clinicians whose practice is focused on women’s health and primary care and who provides**

1 a range of the services within a patient centered primary care home:

2 “(a) A physician who is an obstetrician or gynecologist;

3 “(b) A nurse practitioner;

4 “(c) A physician assistant; or

5 “(d) Another health professional licensed or certified in this state.

6 “[(10)] (14) ‘Total medical expenditures’ means payments to reimburse the cost of physical and
7 mental health care provided to eligible employees or their family members, excluding [*prescription*
8 *drugs,*] vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated
9 rate or other type of payment mechanism.

10 “**SECTION 8.** ORS 243.866 is amended to read:

11 “243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
12 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
13 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
14 phasis on:

15 “(a) Employee choice among high-quality plans;

16 “(b) Encouragement of a competitive marketplace;

17 “(c) Plan performance and information;

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

19 “(e) Quality customer service;

20 “(f) Creativity and innovation;

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

22 “(h) Improvement of employee health; and

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

25 “(2) The board may approve more than one carrier for each type of benefit plan offered, but the
26 board shall limit the number of carriers to a number consistent with adequate service to eligible
27 employees and family members.

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

30 “(4) A district or a local government shall provide that payroll deductions for benefit plan costs
31 that are not payable by the district or local government may be made upon receipt of a signed au-
32 thorization from the employee indicating an election to participate in the benefit plan or plans se-
33 lected and allowing the deduction of those costs from the employee’s pay.

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

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

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

45 “(8) The board shall evaluate a benefit plan that serves a limited geographic region of this state

1 according to the criteria described in subsection (1) of this section.

2 “(9) By January 1, 2023, the board shall spend at least 12 percent of its total medical expen-
3 ditures in self-insured health benefit plans on payments for primary care.

4 **“(10) By January 1, 2020, the board shall reimburse a percentage, as established by rule
5 by the Oregon Health Authority in collaboration with the Department of Consumer and
6 Business Services, of all primary care costs in self-insured health benefit plans offered to
7 eligible employees using alternative payment methodologies, as defined in ORS 414.025.**

8 **“(11) No later than December 1 of each calendar year, the board shall report to the au-
9 thority, with respect to the self-insured health benefit plans offered to eligible employees for
10 the next calendar year:**

11 **“(a) The percentage of total medical expenditures that the board anticipates spending on
12 primary care;**

13 **“(b) The percentage of spending on primary care that will be in the form of alternative
14 payment methodologies; and**

15 **“(c) The types of alternative payment methodologies that will be used to reimburse
16 health care providers.**

17 “[~~(10)~~] **(12)** No later than February 1 of each year, the board shall report to the Legislative
18 Assembly on the board’s progress toward achieving the [*target of spending at least 12 percent of total
19 medical expenditures on payments for primary care*] **spending targets described in subsection (9)
20 of this section and the board’s plan for achieving the targets.**

21 **“SECTION 9.** ORS 243.866, as amended by section 28, chapter 746, Oregon Laws 2017, is
22 amended to read:

23 **“243.866. (1)** The Oregon Educators Benefit Board shall contract for benefit plans best designed
24 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
25 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
26 phasis on:

27 **“(a)** Employee choice among high-quality plans;

28 **“(b)** Encouragement of a competitive marketplace;

29 **“(c)** Plan performance and information;

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

31 **“(e)** Quality customer service;

32 **“(f)** Creativity and innovation;

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

34 **“(h)** Improvement of employee health; and

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

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

45 **“(3)** When appropriate, the board shall provide options under which an eligible employee may

1 arrange coverage for family members under a benefit plan.

2 “(4) A district or a local government shall provide that payroll deductions for benefit plan costs
3 that are not payable by the district or local government may be made upon receipt of a signed au-
4 thorization from the employee indicating an election to participate in the benefit plan or plans se-
5 lected and allowing the deduction of those costs from the employee’s pay.

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

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

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

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

19 “(9)(a) The board shall use payment methodologies in self-insured health benefit plans offered
20 by the board that are designed to limit the growth in per-member expenditures for health services
21 to no more than 3.4 percent per year.

22 “(b) The board shall adopt policies and practices designed to limit the annual increase in pre-
23 mium amounts paid for contracted health benefit plans to 3.4 percent.

24 “(10) A carrier or third party administrator that contracts with the board to provide or admin-
25 ister a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit
26 plan enrollees’ continued eligibility for coverage as spouses or dependents or any other basis that
27 would affect the cost of the premium for the plan.

28 “(11) By January 1, 2023, the board shall spend at least 12 percent of its total medical expen-
29 ditures in self-insured health benefit plans on payments for primary care.

30 **“(12) By January 1, 2020, the board shall reimburse a percentage, as established by rule**
31 **by the Oregon Health Authority in collaboration with the Department of Consumer and**
32 **Business Services, of all primary care costs in self-insured health benefit plans offered to**
33 **eligible employees using alternative payment methodologies, as defined in ORS 414.025.**

34 **“(13) No later than December 1 of each calendar year, the board shall report to the au-**
35 **thority, with respect to the self-insured health benefit plans offered to eligible employees for**
36 **the next calendar year:**

37 **“(a) The percentage of total medical expenditures that the board anticipates spending on**
38 **primary care;**

39 **“(b) The percentage of spending on primary care that will be in the form of alternative**
40 **payment methodologies; and**

41 **“(c) The types of alternative payment methodologies that will be used to reimburse**
42 **health care providers.**

43 “[12] (14) No later than February 1 of each year, the board shall report to the Legislative
44 Assembly on the board’s progress toward achieving the *[target of spending at least 12 percent of total*
45 *medical expenditures on payments for primary care]* **spending targets described in subsection (11)**

1 **of this section and the board’s plan for achieving the targets.**

2 **“SECTION 10.** ORS 243.866, as amended by section 17, chapter 489, Oregon Laws 2017, and
3 section 28, chapter 746, Oregon Laws 2017, is amended to read:

4 “243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
5 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
6 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
7 phasis on:

8 “(a) Employee choice among high-quality plans;

9 “(b) Encouragement of a competitive marketplace;

10 “(c) Plan performance and information;

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

12 “(e) Quality customer service;

13 “(f) Creativity and innovation;

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

15 “(h) Improvement of employee health; and

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

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

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

28 “(4) A district or a local government shall provide that payroll deductions for benefit plan costs
29 that are not payable by the district or local government may be made upon receipt of a signed au-
30 thorization from the employee indicating an election to participate in the benefit plan or plans se-
31 lected and allowing the deduction of those costs from the employee’s pay.

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

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

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

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

45 “(9)(a) The board shall use payment methodologies in self-insured health benefit plans offered

1 by the board that are designed to limit the growth in per-member expenditures for health services
2 to no more than 3.4 percent per year.

3 “(b) The board shall adopt policies and practices designed to limit the annual increase in pre-
4 mium amounts paid for contracted health benefit plans to 3.4 percent.

5 “(10) A carrier or third party administrator that contracts with the board to provide or admin-
6 ister a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit
7 plan enrollees’ continued eligibility for coverage as spouses or dependents or any other basis that
8 would affect the cost of the premium for the plan.

9 “(11) **The board shall:**

10 “(a) **Spend at least 12 percent of its total medical expenditures in self-insured health**
11 **benefit plans on payments for primary care; and**

12 “(b) **Reimburse a percentage, as established by rule by the Oregon Health Authority in**
13 **collaboration with the Department of Consumer and Business Services, of all primary care**
14 **costs in self-insured health benefit plans that are offered to eligible employees using alter-**
15 **native payment methodologies, as defined in ORS 414.025.**

16 “[*(11)*] (12) If the board [*spends less than 12 percent of its total medical expenditures in self-*
17 *insured health benefit plans on payments for primary care*] **fails to meet the financial requirements**
18 **described in subsection (11) of this section**, the board shall implement a plan for increasing, **by**
19 **at least one percent each year:**

20 “(a) The percentage of total medical expenditures spent on payments for primary care [*by at*
21 *least one percent each year*]; **and**

22 “(b) **The percentage of primary care costs that are reimbursed using alternative payment**
23 **methodologies.**

24 “(13) **No later than December 1 of each calendar year, the board shall report to the au-**
25 **thority, with respect to the self-insured health benefit plans offered to eligible employees for**
26 **the next calendar year:**

27 “(a) **The percentage of total medical expenditures that the board anticipates spending on**
28 **primary care;**

29 “(b) **The percentage of spending on primary care that will be in the form of alternative**
30 **payment methodologies; and**

31 “(c) **The types of alternative payment methodologies that will be used to reimburse**
32 **health care providers.**

33 “[*(12)*] (14) No later than February 1 of each year, the board shall report to the Legislative
34 Assembly on any plan implemented under subsection [*(11)*] (12) of this section and on the board’s
35 progress toward achieving the [*target of spending at least 12 percent of total medical expenditures on*
36 *payments for primary care*] **financial requirements described in subsection (11) of this section.**

37 “**SECTION 10a.** ORS 279A.025 is amended to read:

38 “279A.025. (1) Except as provided in subsections (2) to (4) of this section, the Public Contracting
39 Code applies to all public contracting.

40 “(2) The Public Contracting Code does not apply to:

41 “(a) Contracts between a contracting agency and:

42 “(A) Another contracting agency;

43 “(B) The Oregon Health and Science University;

44 “(C) A public university listed in ORS 352.002;

45 “(D) The Oregon State Bar;

1 “(E) A governmental body of another state;
2 “(F) The federal government;
3 “(G) An American Indian tribe or an agency of an American Indian tribe;
4 “(H) A nation, or a governmental body in a nation, other than the United States; or
5 “(I) An intergovernmental entity formed between or among:
6 “(i) Governmental bodies of this or another state;
7 “(ii) The federal government;
8 “(iii) An American Indian tribe or an agency of an American Indian tribe;
9 “(iv) A nation other than the United States; or
10 “(v) A governmental body in a nation other than the United States;
11 “(b) Agreements authorized by ORS chapter 190 or by a statute, charter provision, ordinance
12 or other authority for establishing agreements between or among governmental bodies or agencies
13 or tribal governing bodies or agencies;
14 “(c) Insurance and service contracts as provided for under ORS 414.115, 414.125, 414.135 and
15 414.145 for purposes of source selection;
16 “(d) Grants;
17 “(e) Contracts for professional or expert witnesses or consultants to provide services or testi-
18 mony relating to existing or potential litigation or legal matters in which a public body is or may
19 become interested;
20 “(f) Acquisitions or disposals of real property or interest in real property;
21 “(g) Sole-source expenditures when rates are set by law or ordinance for purposes of source
22 selection;
23 “(h) Contracts for the procurement or distribution of textbooks;
24 “(i) Procurements by a contracting agency from an Oregon Corrections Enterprises program;
25 “(j) The procurement, transportation, sale or distribution of distilled liquor, as defined in ORS
26 471.001, or the appointment of agents under ORS 471.230 or 471.750 by the Oregon Liquor Control
27 Commission;
28 “(k) Contracts entered into under ORS chapter 180 between the Attorney General and private
29 counsel or special legal assistants;
30 “(L) Contracts for the sale of timber from lands owned or managed by the State Board of
31 Forestry and the State Forestry Department;
32 “(m) Contracts for activities necessary or convenient for the sale of timber under paragraph (L)
33 of this subsection, either separately from or in conjunction with contracts for the sale of timber,
34 including but not limited to activities such as timber harvesting and sorting, transporting, gravel
35 pit development or operation, and road construction, maintenance or improvement;
36 “(n) Contracts for forest protection or forest related activities, as described in ORS 477.406, by
37 the State Forester or the State Board of Forestry;
38 “(o) Contracts entered into by the Housing and Community Services Department in exercising
39 the department’s duties prescribed in ORS chapters 456 and 458, except that the department’s public
40 contracting for goods and services is subject to ORS chapter 279B;
41 “(p) Contracts entered into by the State Treasurer in exercising the powers of that office pre-
42 scribed in ORS 178.010 to 178.090 and 276A.242 and ORS chapters 286A, 287A, 289, 293, 294 and 295,
43 including but not limited to investment contracts and agreements, banking services, clearing house
44 services and collateralization agreements, bond documents, certificates of participation and other
45 debt repayment agreements, and any associated contracts, agreements and documents, regardless of

1 whether the obligations that the contracts, agreements or documents establish are general, special
2 or limited, except that the State Treasurer's public contracting for goods and services is subject to
3 ORS chapter 279B;

4 "(q) Contracts, agreements or other documents entered into, issued or established in connection
5 with:

6 "(A) The issuance of obligations, as defined in ORS 286A.100 and 287A.310, of a public body;

7 "(B) The making of program loans and similar extensions or advances of funds, aid or assistance
8 by a public body to a public or private body for the purpose of carrying out, promoting or sustaining
9 activities or programs authorized by law; or

10 "(C) The investment of funds by a public body as authorized by law, and other financial trans-
11 actions of a public body that by their character cannot practically be established under the com-
12 petitive contractor selection procedures of ORS 279B.050 to 279B.085;

13 "(r) Contracts for employee benefit plans as provided in ORS 243.105 [(1)] (2), 243.125 (4),
14 243.221, 243.275, 243.291, 243.303 and 243.565;

15 "(s) Contracts for employee benefit plans as provided in ORS 243.860 to 243.886; or

16 "(t) Any other public contracting of a public body specifically exempted from the code by an-
17 other provision of law.

18 "(3) The Public Contracting Code does not apply to the contracting activities of:

19 "(a) The Oregon State Lottery Commission;

20 "(b) The legislative department;

21 "(c) The judicial department;

22 "(d) Semi-independent state agencies listed in ORS 182.454, except as provided in ORS 279.835
23 to 279.855 and 279A.250 to 279A.290;

24 "(e) Oregon Corrections Enterprises;

25 "(f) The Oregon Film and Video Office, except as provided in ORS 279A.100 and 279A.250 to
26 279A.290;

27 "(g) The Travel Information Council, except as provided in ORS 279A.250 to 279A.290;

28 "(h) The Oregon 529 Savings Network and the Oregon 529 Savings Board;

29 "(i) The Oregon Innovation Council;

30 "(j) The Oregon Utility Notification Center; or

31 "(k) Any other public body specifically exempted from the code by another provision of law.

32 "(4) ORS 279A.200 to 279A.225 and 279B.050 to 279B.085 do not apply to contracts made with
33 qualified nonprofit agencies providing employment opportunities for individuals with disabilities un-
34 der ORS 279.835 to 279.855.

35 "**SECTION 11.** ORS 414.653 is amended to read:

36 "414.653. (1) The Oregon Health Authority shall encourage coordinated care organizations to
37 use alternative payment methodologies that:

38 "(a) Reimburse providers on the basis of health outcomes and quality measures instead of the
39 volume of care;

40 "(b) Hold organizations and providers responsible for the efficient delivery of quality care;

41 "(c) Reward good performance;

42 "(d) Limit increases in medical costs; and

43 "(e) Use payment structures that create incentives to:

44 "(A) Promote prevention;

45 "(B) Provide person centered care; and

1 “(C) Reward comprehensive care coordination using delivery models such as patient centered
2 primary care homes and behavioral health homes.

3 “(2) The authority shall encourage coordinated care organizations to utilize alternative payment
4 methodologies that move from a predominantly fee-for-service system to payment methods that base
5 reimbursement on the quality rather than the quantity of services provided.

6 “[*(3) A coordinated care organization that participates in a national primary care medical home
7 payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42
8 U.S.C. 1315a, that includes performance-based incentive payments for primary care, shall offer similar
9 alternative payment methodologies to all patient centered primary care homes identified in accordance
10 with ORS 413.259 that serve members of the coordinated care organization.*]

11 “[*(4)*] (3) The authority shall assist and support coordinated care organizations in identifying
12 cost-cutting measures.

13 “[*(5)*] (4) If a service provided in a health care facility is not covered by Medicare because the
14 service is related to a health care acquired condition, the cost of the service may not be:

15 “(a) Charged by a health care facility or any health services provider employed by or with
16 privileges at the facility, to a coordinated care organization, a patient or a third-party payer; or

17 “(b) Reimbursed by a coordinated care organization.

18 “[*(6)(a)*] (5)(a) Notwithstanding subsections (1) and (2) of this section, until July 1, 2014, a co-
19 ordinated care organization that contracts with a Type A or Type B hospital or a rural critical ac-
20 cess hospital, as described in ORS 442.470, shall reimburse the hospital fully for the cost of covered
21 services based on the cost-to-charge ratio used for each hospital in setting the global payments to
22 the coordinated care organization for the contract period.

23 “(b) The authority shall base the global payments to coordinated care organizations that con-
24 tract with rural hospitals described in this section on the most recent audited Medicare cost report
25 for Oregon hospitals adjusted to reflect the Medicaid mix of services.

26 “(c) The authority shall identify any rural hospital that would not be expected to remain finan-
27 cially viable if paid in a manner other than as prescribed in paragraphs (a) and (b) of this subsection
28 based upon an evaluation by an actuary retained by the authority. On and after July 1, 2014, the
29 authority may, on a case-by-case basis, require a coordinated care organization to continue to re-
30 imburse a rural hospital determined to be at financial risk, in the manner prescribed in paragraphs
31 (a) and (b) of this subsection.

32 “(d) This subsection does not prohibit a coordinated care organization and a hospital from mu-
33 tually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this
34 subsection.

35 “(e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection are not entitled to any
36 additional reimbursement for services provided.

37 “[*(7)*] (6) Notwithstanding subsections (1) and (2) of this section, coordinated care organizations
38 must comply with federal requirements for payments to providers of Indian health services, including
39 but not limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

40 “**SECTION 12.** ORS 743.010, as amended by section 15, chapter 489, Oregon Laws 2017, is
41 amended to read:

42 “743.010. (1) In addition to all other powers of the Director of the Department of Consumer and
43 Business Services with respect thereto, the director may issue rules with respect to policy forms and
44 health benefit plan forms described in ORS 742.005 (6)(a) and (b):

45 “(a) Establishing minimum benefit standards;

1 “(b) Requiring the ratio of benefits to premiums to be not less than a specified percentage in
2 order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the
3 insurer’s compliance;

4 “(c) Establishing requirements intended to discourage duplication or overlapping of coverage
5 and replacement, without regard to the advantage to policyholders, of existing policies by new pol-
6 icies; [and]

7 “(d) Establishing requirements [for] to **encourage** carriers offering health benefit plans to:

8 “(A) Spend at least 12 percent of total medical expenditures on payments for primary care; **and**

9 “(B) **Reimburse a percentage, as established by the director by rule, in collaboration with**
10 **the Oregon Health Authority, of all primary care costs using alternative payment method-**
11 **ologies;**

12 “(e) **Requiring carriers to submit with each rate filing a plan to increase, by at least one**
13 **percent each plan year:**

14 “(A) **The percentage of total medical expenditures spent on payments for primary care;**
15 **and**

16 “(B) **The percentage of primary care costs that are reimbursed using alternative payment**
17 **methodologies; and**

18 “(f) **Requiring carriers to report to the authority, no later than December 1 of each cal-**
19 **endar year, specifying for the next calendar year:**

20 “(A) **The percentage of total medical expenditures that the carrier anticipates spending**
21 **on primary care;**

22 “(B) **The percentage of spending on primary care that will be made using alternative**
23 **payment methodologies; and**

24 “(C) **The types of payment methodologies that will be used to reimburse health care**
25 **providers.**

26 “(2) As used in this section:

27 “(a) **‘Alternative payment methodology’ has the meaning given that term in ORS 414.025.**

28 “(b) **‘Behavioral health clinician’ means:**

29 “(A) **A psychiatrist;**

30 “(B) **A psychologist licensed under ORS 675.010 to 675.150;**

31 “(C) **A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psy-**
32 **chiatric mental health;**

33 “(D) **A clinical social worker licensed under ORS 675.530;**

34 “(E) **A marriage and family therapist or professional counselor licensed under ORS**
35 **675.715;**

36 “(F) **A clinical social work associate certified under ORS 675.537; or**

37 “(G) **An intern or resident who is working under a board-approved supervisory contract**
38 **in a clinical mental health field.**

39 “(c) **‘Patient centered primary care home’ has the meaning given that term in ORS**
40 **414.025.**

41 “[(a)] (d) **‘Primary care’ means family medicine, general internal medicine, naturopathic medi-**
42 **cine, [obstetrics and gynecology,] pediatrics [or general psychiatry] and care provided by primary**
43 **care integrated behavioral health clinicians or primary care integrated women’s health**
44 **clinicians.**

45 “(e) **‘Primary care integrated behavioral health clinician’ means:**

1 “(A) A care team member, as defined in ORS 414.025 (15)(b); or
2 “(B) A behavioral health clinician providing care to individuals and families in a patient
3 centered primary care home to address one or more of the following:
4 “(i) Mental illness.
5 “(ii) Substance use disorders.
6 “(iii) Health behaviors that contribute to chronic illness.
7 “(iv) Life stressors and crises.
8 “(v) Developmental risks and conditions.
9 “(vi) Stress-related physical symptoms.
10 “(vii) Preventive care.
11 “(viii) Ineffective patterns of health care utilization.
12 “(f) ‘Primary care integrated women’s health clinician’ means one of the following
13 clinicians whose practice is focused on women’s health and primary care and who provides
14 a range of the services within a patient centered primary care home:
15 “(A) A physician who is an obstetrician or gynecologist;
16 “(B) A nurse practitioner;
17 “(C) A physician assistant; or
18 “(D) Another health professional licensed or certified in this state.
19 “[(b)] (g) ‘Total medical expenditures’ means payments to reimburse the cost of physical and
20 mental health care provided to enrollees, excluding [*prescription drugs*,] vision care and dental care,
21 whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment
22 mechanism.
23 “**SECTION 13.** ORS 743.010, as amended by section 15, chapter 489, Oregon Laws 2017, and
24 section 12 of this 2019 Act, is amended to read:
25 “743.010. (1) In addition to all other powers of the Director of the Department of Consumer and
26 Business Services with respect thereto, the director may issue rules with respect to policy forms and
27 health benefit plan forms described in ORS 742.005 (6)(a) and (b):
28 “(a) Establishing minimum benefit standards;
29 “(b) Requiring the ratio of benefits to premiums to be not less than a specified percentage in
30 order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the
31 insurer’s compliance;
32 “(c) Establishing requirements intended to discourage duplication or overlapping of coverage
33 and replacement, without regard to the advantage to policyholders, of existing policies by new pol-
34 icies;
35 “(d) Establishing requirements [*to encourage*] **for** carriers offering health benefit plans to:
36 “(A) Spend at least 12 percent of total medical expenditures on payments for primary care; and
37 “(B) Reimburse a percentage, as established by the director by rule, in collaboration with the
38 Oregon Health Authority, of all primary care costs using alternative payment methodologies; **and**
39 “[(e) *Requiring carriers to submit with each rate filing a plan to increase, by at least one percent*
40 *each plan year:*]
41 “[(A) *The percentage of total medical expenditures spent on payments for primary care; and*]
42 “[(B) *The percentage of primary care costs that are reimbursed using alternative payment method-*
43 *ologies; and*]
44 “[(f)] (e) Requiring carriers to report to the authority, no later than December 1 of each calen-
45 dar year, specifying for the next calendar year:

1 “(A) The percentage of total medical expenditures that the carrier anticipates spending on pri-
2 mary care;

3 “(B) The percentage of spending on primary care that will be made using alternative payment
4 methodologies; and

5 “(C) The types of payment methodologies that will be used to reimburse health care providers.

6 “(2) As used in this section:

7 “(a) ‘Alternative payment methodology’ has the meaning given that term in ORS 414.025.

8 “(b) ‘Behavioral health clinician’ means:

9 “(A) A psychiatrist;

10 “(B) A psychologist licensed under ORS 675.010 to 675.150;

11 “(C) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psychiatric
12 mental health;

13 “(D) A clinical social worker licensed under ORS 675.530;

14 “(E) A marriage and family therapist or professional counselor licensed under ORS 675.715;

15 “(F) A clinical social work associate certified under ORS 675.537; or

16 “(G) An intern or resident who is working under a board-approved supervisory contract in a
17 clinical mental health field.

18 “(c) ‘Patient centered primary care home’ has the meaning given that term in ORS 414.025.

19 “(d) ‘Primary care’ means family medicine, general internal medicine, naturopathic medicine,
20 pediatrics and care provided by primary care integrated behavioral health clinicians or primary care
21 integrated women’s health clinicians.

22 “(e) ‘Primary care integrated behavioral health clinician’ means:

23 “(A) A care team member, as defined in ORS 414.025 (15)(b); or

24 “(B) A behavioral health clinician providing care to individuals and families in a patient cen-
25 tered primary care home to address one or more of the following:

26 “(i) Mental illness.

27 “(ii) Substance use disorders.

28 “(iii) Health behaviors that contribute to chronic illness.

29 “(iv) Life stressors and crises.

30 “(v) Developmental risks and conditions.

31 “(vi) Stress-related physical symptoms.

32 “(vii) Preventive care.

33 “(viii) Ineffective patterns of health care utilization.

34 “(f) ‘Primary care integrated women’s health clinician’ means one of the following clinicians
35 whose practice is focused on women’s health and primary care and who provides a range of the
36 services within a patient centered primary care home:

37 “(A) A physician who is an obstetrician or gynecologist;

38 “(B) A nurse practitioner;

39 “(C) A physician assistant; or

40 “(D) Another health professional licensed or certified in this state.

41 “(g) ‘Total medical expenditures’ means payments to reimburse the cost of physical and mental
42 health care provided to enrollees, excluding vision care and dental care, whether paid on a fee-for-
43 service basis or as part of a capitated rate or other type of payment mechanism.

44 “**SECTION 14.** Section 1, chapter 575, Oregon Laws 2015, as amended by section 12, chapter
45 489, Oregon Laws 2017, is amended to read:

1 **“Sec. 1.** (1) As used in this section:

2 “(a) ‘Carrier’ means an insurer that offers a health benefit plan, as defined in ORS 743B.005.

3 “(b) ‘Prominent carrier’ means:

4 “(A) A carrier with annual premium income at a threshold, of no less than \$50 million, estab-

5 lished by the Department of Consumer and Business Services by rule.

6 “(B) The Public Employees’ Benefit Board.

7 “(C) The Oregon Educators Benefit Board.

8 “(2) All prominent carriers shall, and carriers other than prominent carriers may, report to the

9 Department of Consumer and Business Services, no later than October 1 of each year, the proportion

10 of the carrier’s total medical [*expenses*] **expenditures** that are allocated to primary care.

11 “(3) The department shall share with the Oregon Health Authority the information reported so

12 that the authority may prepare the evaluation and [*report*] **reports** described in [*section 2*] **sections**

13 **2 and 3**, chapter 575, Oregon Laws 2015.

14 “(4) The department, in collaboration with the authority, shall adopt rules prescribing the pri-

15 mary care services for which costs must be reported under subsection (2) of this section.

16 **“SECTION 15.** Section 2, chapter 575, Oregon Laws 2015, as amended by section 1, chapter 384,

17 Oregon Laws 2017, and section 13, chapter 489, Oregon Laws 2017, is amended to read:

18 **“Sec. 2.** (1) As used in this section:

19 “(a) **‘Behavioral health clinician’ means:**

20 **“(A) A psychiatrist;**

21 **“(B) A psychologist licensed under ORS 675.010 to 675.150;**

22 **“(C) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psy-**

23 **chiatric mental health;**

24 **“(D) A clinical social worker licensed under ORS 675.530;**

25 **“(E) A marriage and family therapist or professional counselor licensed under ORS**

26 **675.715;**

27 **“(F) A clinical social work associate certified under ORS 675.537; or**

28 **“(G) An intern or resident who is working under a board-approved supervisory contract**

29 **in a clinical mental health field.**

30 “[(a)] (b) ‘Carrier’ means an insurer that offers a health benefit plan, as defined in ORS

31 743B.005.

32 “[(b)] (c) ‘Coordinated care organization’ has the meaning given that term in ORS 414.025.

33 “(d) **‘Patient centered primary care home’ has the meaning given that term in ORS**

34 **414.025.**

35 “[(c)] (e) ‘Primary care’ means family medicine, general internal medicine, naturopathic medi-

36 cine, [*obstetrics and gynecology,*] pediatrics [*or general psychiatry*] **and care provided by primary**

37 **care integrated behavioral health clinicians or primary care integrated women’s health**

38 **clinicians.**

39 “(f) **‘Primary care integrated behavioral health clinician’ means:**

40 **“(A) A care team member as defined in ORS 414.025 (15)(b); or**

41 **“(B) A behavioral health clinician providing care to individuals and families in a patient**

42 **centered primary care home to address one or more of the following:**

43 **“(i) Mental illness.**

44 **“(ii) Substance use disorders.**

45 **“(iii) Health behaviors that contribute to chronic illness.**

1 “(iv) **Life stressors and crises.**
2 “(v) **Developmental risks and conditions.**
3 “(vi) **Stress-related physical symptoms.**
4 “(vii) **Preventive care.**
5 “(viii) **Ineffective patterns of health care utilization.**
6 “(g) **‘Primary care integrated women’s health clinician’ means one of the following**
7 **clinicians whose practice is focused on women’s health and primary care and who provides**
8 **a range of the services within a patient centered primary care home:**
9 “(A) **A physician who is an obstetrician or gynecologist;**
10 “(B) **A nurse practitioner;**
11 “(C) **A physician assistant; or**
12 “(D) **Another health professional licensed or certified in this state.**
13 “[(d)] (h) **‘Primary care provider’ includes:**
14 “(A) **A physician, naturopath, nurse practitioner, physician assistant or other health professional**
15 **licensed or certified in this state, whose clinical practice is in the area of primary care.**
16 “(B) **A health care team or clinic that has been certified by the Oregon Health Authority as a**
17 **patient centered primary care home.**
18 “(2)(a) **The Oregon Health Authority shall convene a primary care payment reform collaborative**
19 **to advise and assist in the implementation of a Primary Care Transformation Initiative to:**
20 “(A) **Use value-based payment methods that are not paid on a per claim basis to:**
21 “(i) **Increase the investment in primary care;**
22 “(ii) **Align primary care reimbursement by all purchasers of care; and**
23 “(iii) **Continue to improve reimbursement methods, including by investing in the social determi-**
24 **nants of health;**
25 “(B) **Increase investment in primary care without increasing costs to consumers or increasing**
26 **the total cost of health care;**
27 “(C) **Provide technical assistance to clinics and payers in implementing the initiative;**
28 “(D) **Aggregate the data from and align the metrics used in the initiative with the work of the**
29 **Health Plan Quality Metrics Committee established in ORS 413.017;**
30 “(E) **Facilitate the integration of primary care behavioral and physical health care; and**
31 “(F) **Ensure that the goals of the initiative are met by December 31, 2027.**
32 “(b) **The collaborative is a governing body, as defined in ORS 192.610.**
33 “(3) **The authority shall invite representatives from all of the following to participate in the**
34 **primary care payment reform collaborative:**
35 “(a) **Primary care providers;**
36 “(b) **Health care consumers;**
37 “(c) **Experts in primary care contracting and reimbursement;**
38 “(d) **Independent practice associations;**
39 “(e) **Behavioral health treatment providers;**
40 “(f) **Third party administrators;**
41 “(g) **Employers that offer self-insured health benefit plans;**
42 “(h) **The Department of Consumer and Business Services;**
43 “(i) **Carriers;**
44 “(j) **A statewide organization for mental health professionals who provide primary care;**
45 “(k) **A statewide organization representing federally qualified health centers;**

1 “(L) A statewide organization representing hospitals and health systems;

2 “(m) A statewide professional association for family physicians;

3 “(n) A statewide professional association for physicians;

4 “(o) A statewide professional association for nurses; and

5 “(p) The Centers for Medicare and Medicaid Services.

6 “(4) The primary care payment reform collaborative shall annually report to the Oregon Health
7 Policy Board and to the Legislative Assembly on the achievement of the primary care [*spending*
8 *targets*] **financial requirements** in ORS 414.625 and 743.010 and the implementation of the Primary
9 Care Transformation Initiative.

10 “(5) A coordinated care organization shall report to the authority, no later than October 1 of
11 each year, the proportion of the organization’s total medical [*costs*] **expenditures** that are allocated
12 to primary care.

13 “(6) The authority, in collaboration with the Department of Consumer and Business Services,
14 shall adopt rules prescribing the primary care services for which costs must be reported under
15 subsection (5) of this section.

16 “**SECTION 16.** Section 3, chapter 575, Oregon Laws 2015, as amended by section 7, chapter 26,
17 Oregon Laws 2016, is amended to read:

18 “**Sec. 3.** No later than February 1 of each year, the Oregon Health Authority and the Depart-
19 ment of Consumer and Business Services shall report to the Legislative Assembly, in the manner
20 provided in ORS 192.245:

21 “(1) The percentage of the medical expenses of carriers, coordinated care organizations, the
22 Public Employees’ Benefit Board and the Oregon Educators Benefit Board that is allocated to pri-
23 mary care; [*and*]

24 “(2) How carriers, coordinated care organizations, the Public Employees’ Benefit Board and the
25 Oregon Educators Benefit Board pay for primary care; **and**

26 “(3) **As reported to the authority and the Department of Consumer and Business Services**
27 **under ORS 243.135 and 243.866 and section 2 of this 2019 Act:**

28 “(a) **The percentage of total medical expenditures that carriers, coordinated care organ-**
29 **izations, the Oregon Educators Benefit Board and the Public Employees’ Benefit Board an-**
30 **anticipate spending on primary care for the calendar year;**

31 “(b) **The percentage of spending on primary care by carriers, coordinated care organiza-**
32 **tions, the Oregon Educators Benefit Board and the Public Employees’ Benefit Board that**
33 **will be in the form of alternative payment methodologies, as defined in ORS 414.025, in the**
34 **calendar year; and**

35 “(c) **The types of alternative payment methodologies that carriers, coordinated care or-**
36 **ganizations, the Oregon Educators Benefit Board and the Public Employees’ Benefit Board**
37 **will use in the calendar year.**

38 “**SECTION 17.** Section 2 of this 2019 Act is amended to read:

39 “**Sec. 2.** (1) As used in this section:

40 “(a) ‘Behavioral health clinician’ means:

41 “(A) A psychiatrist;

42 “(B) A psychologist licensed under ORS 675.010 to 675.150;

43 “(C) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psychiatric
44 mental health;

45 “(D) A clinical social worker licensed under ORS 675.530;

1 “(E) A marriage and family therapist or professional counselor licensed under ORS 675.715;
2 “(F) A clinical social work associate certified under ORS 675.537; or
3 “(G) An intern or resident who is working under a board-approved supervisory contract in a
4 clinical mental health field.
5 “(b) ‘Primary care’ means family medicine, general internal medicine, naturopathic medicine,
6 pediatrics and care provided by primary care integrated behavioral health clinicians or primary care
7 integrated women’s health clinicians.
8 “(c) ‘Primary care integrated behavioral health clinician’ means:
9 “(A) A care team member as defined in ORs 414.025 (15)(b); or
10 “(B) A behavioral health clinician providing care to individuals and families in a patient cen-
11 tered primary care home to address one or more of the following:
12 “(i) Mental illness.
13 “(ii) Substance use disorders.
14 “(iii) Health behaviors that contribute to chronic illness.
15 “(iv) Life stressors and crises.
16 “(v) Developmental risks and conditions.
17 “(vi) Stress-related physical symptoms.
18 “(vii) Preventive care.
19 “(viii) Ineffective patterns of health care utilization.
20 “(d) ‘Primary care integrated women’s health clinician’ means one of the following clinicians
21 whose practice is focused on women’s health and primary care and who provides a range of the
22 services within a patient centered primary care home:
23 “(A) A physician who is an obstetrician or gynecologist;
24 “(B) A nurse practitioner;
25 “(C) A physician assistant; or
26 “(D) Another health professional licensed or certified in this state.
27 “(e) ‘Total medical expenditures’ means total expenditures for physical and mental health care
28 provided to members of a coordinated care organization, excluding expenditures for vision care and
29 dental care.
30 “(2) [No later than January 1, 2023,] A coordinated care organization must spend at least 12
31 percent of the coordinated care organization’s total medical expenditures on primary care.
32 “(3) [No later than January 1, 2020,] A coordinated care organization must reimburse a per-
33 centage, as established by the Oregon Health Authority by rule, of all primary care costs using al-
34 ternative payment methodologies.
35 “(4) After the Oregon Health Authority has established a global budget for a coordinated care
36 organization for a calendar year, the coordinated care organization shall report to the authority,
37 at the time and in the manner prescribed by the authority by rule:
38 “(a) The percentage of the global budget that the coordinated care organization anticipates
39 spending on primary care;
40 “(b) The percentage of the spending on primary care that will be in the form of alternative
41 payment methodologies; and
42 “(c) The types of alternative payment methodologies that the coordinated care organization will
43 use during the calendar year.”.
44 On page 24, line 27, after “(2)” insert “and (3)”.
45 In line 43, delete “15” and insert “14”.

- 1 In line 45, delete “16” and insert “15”.
- 2 On page 25, line 3, after the first comma insert “and section 16 of this 2019 Act”.
- 3 _____