

A-Engrossed
Senate Bill 770

Ordered by the Senate April 16
Including Senate Amendments dated April 16

Sponsored by Senators MANNING JR, DEMBROW, BEYER, Representatives FAHEY, KENY-GUYER, SALINAS, WILLIAMSON; Senators BURDICK, FAGAN, FREDERICK, GELSER, GOLDEN, HASS, PROZANSKI, RILEY, TAYLOR, WAGNER, Representatives ALONSO LEON, BYNUM, DOHERTY, GOMBERG, GORSEK, HELM, HERNANDEZ, HOLVEY, MARSH, MCLAIN, MEEK, MITCHELL, NERON, NOSSE, PILUSO, POWER, PRUSAK, RAYFIELD, REARDON, SANCHEZ, SCHOUTEN, SMITH WARNER, WILDE, WITT

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.

[Establishes Health Care for All Oregon Board to be responsible for planning and oversight of Health Care for All Oregon Plan to be administered by Oregon Health Authority. Provides comprehensive health care coverage to all individuals residing or working in Oregon. Repeals health insurance exchange upon implementation of Health Care for All Oregon Plan.]

[Supplants coverage by private insurers for health services covered by plan. Authorizes Public Employees' Benefit Board and Oregon Educators Benefit Board to offer supplemental health benefit plans to employees. Requires public employees to be covered by Health Care for All Oregon Plan.]

[Establishes Health Care for All Oregon Fund. Continuously appropriates moneys in fund to Health Care for All Oregon Board.]

[Establishes office of Health Care for All Oregon Ombudsman in office of Governor.]

[Requires Health Care for All Oregon Board to establish Regional Planning Boards to oversee allocation of health resources in geographic regions prescribed by Health Care for All Oregon Board. Requires submission to Regional Planning Board of plans for addition, alteration or construction of health care facility except long term care facility. Authorizes Health Care for All Oregon Board to provide public funding upon request if addition, alteration or construction approved. Transfers to Department of Human Services authority to approve certificate of need for long term care facility.]

[Appropriates moneys from General Fund to Health Care for All Oregon Board for purposes of Health Care for All Oregon Plan.]

Establishes Universal Health Care Commission charged with recommending to Legislative Assembly design of Health Care for All Oregon Plan, administered by Health Care for All Oregon Board to provide publicly funded, equitable, affordable, comprehensive and high quality health care to all Oregon residents. Specifies membership and duties of commission. Requires recommendations to be guided by specified values and principles. Prescribes requirements for plan design and items that commission must consider.

Requires commission to first meet by November 1, 2019, and provide first report to interim committees of Legislative Assembly related to health by March 15, 2020. Requires commission to submit to Legislative Assembly final recommendations by February 1, 2021, or report on work that remains to be completed.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to statewide health care coverage; and declaring an emergency.

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

SECTION 1. Establishment of the Universal Health Care Commission. (1) The Universal Health Care Commission is established to recommend the design of the Health Care for All Oregon Plan, a universal health care system administered by the Health Care for All Oregon Board that is equitable, affordable, comprehensive, provides high quality health care, is publicly funded and available to every individual residing in Oregon.

(2) The commission consists of 18 members appointed as follows:

(a) The President of the Senate shall appoint two members from among members of the

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.

1 **Senate.**

2 **(b) The Speaker of the House of Representatives shall appoint two members from among**
3 **members of the House of Representatives.**

4 **(c) The Governor shall appoint 13 members who reside in this state and who:**

5 **(A) Represent, at a minimum, the following areas of expertise or knowledge, either by life**
6 **experience or by other means:**

7 **(i) Rural and urban community values and equity accountability;**

8 **(ii) Fiscal management or change management;**

9 **(iii) Social services, public health services and medical and surgical services;**

10 **(iv) Alternative therapy services, disability services and nursing services; and**

11 **(v) Experience seeking or receiving health care in this state for one or more serious**
12 **medical conditions or disabilities;**

13 **(B) Represent diversity to the greatest extent practicable, including geographic, age,**
14 **ethnic, gender and gender nonconforming, racial, economic and disability or health status**
15 **diversity;**

16 **(C) Offer expertise, knowledge or experience in patient advocacy, management of a**
17 **company that offers health insurance to its employees, public health, finance, public policy,**
18 **organized labor, health care or the operation of a small business;**

19 **(D) Include at least two members who receive medical assistance;**

20 **(E) Include at least one member who either has health insurance offered by the Public**
21 **Employees' Benefit Board or the Oregon Educators Benefit Board or who represents public**
22 **employees who have such health insurance;**

23 **(F) Include at least one member who has employer-sponsored, commercial or self-insured**
24 **health insurance coverage;**

25 **(G) Include at least one member who purchases commercial health insurance without**
26 **any employer contribution;**

27 **(H) Include at least two members who are enrolled in Medicare, at least one of whom is**
28 **not also a recipient of medical assistance and at least one of whom is under the age of 65;**

29 **(I) Include at least one member who receives health care from the Indian Health Service;**
30 **and**

31 **(J) Include at least one member who has an active license to provide health care in this**
32 **state, appointed in addition to the members offering expertise, knowledge and experience in**
33 **providing health care described in subparagraph (A) of this paragraph.**

34 **(d) The Director of the Oregon Health Authority or the director's designee who is a**
35 **nonvoting member.**

36 **(3) In making the appointments under subsection (2)(c) of this section, the Governor shall**
37 **ensure that there is no disproportionate influence by any individual, organization, govern-**
38 **ment, industry, business or profession in any decision-making by the commission and no**
39 **actual or potential conflicts of interest.**

40 **(4) A majority of the voting members of the commission constitutes a quorum for the**
41 **transaction of business.**

42 **(5) Official action by the commission requires the approval of a majority of the voting**
43 **members of the commission.**

44 **(6) The commission shall elect one of its members to serve as chairperson and one to**
45 **serve as vice chairperson.**

1 (7) If there is a vacancy for any cause, the appointing authority shall make an appoint-
2 ment to become immediately effective.

3 (8) The commission shall meet at times and places specified by the call of the chairperson
4 or of a majority of the voting members of the commission.

5 (9) The commission may adopt rules necessary for the operation of the commission.

6 (10) The commission may establish any advisory or technical committee the commission
7 considers necessary. The committees may be continuing or temporary. The commission shall
8 determine the representation, membership, terms and organization of the committees and
9 shall appoint the members of the committees.

10 (11) The Legislative Policy and Research Director shall provide staff support to the
11 commission.

12 (12) The commission may apply for public or private grants from nonprofit organizations
13 for the costs of research.

14 (13) Members of the Legislative Assembly appointed to the commission are nonvoting
15 members of the commission and may act in an advisory capacity only.

16 (14) Members of the commission are entitled to compensation and expenses as provided
17 in ORS 292.495.

18 (15) Members of the advisory or technical committees are not entitled to compensation
19 but, in the discretion of the commission, may be reimbursed for actual and necessary travel
20 and other expenses incurred by the members of the advisory or technical committees in the
21 performance of official duties in the manner and amount provided in ORS 292.495.

22 (16) All agencies of state government, as defined in ORS 174.111, are directed to assist
23 the commission in the performance of the duties of the commission and, to the extent per-
24 mitted by laws relating to confidentiality, to furnish information and advice the members of
25 the commission consider necessary to perform their duties.

26 **SECTION 2. Purpose.** The Universal Health Care Commission shall produce findings and
27 recommendations, reported to the Legislative Assembly as provided in section 5 of this 2019
28 Act, for a well-functioning universal health care system that is responsive to the needs and
29 expectations of the residents of this state by:

30 (1) Improving the health status of individuals, families and communities;

31 (2) Defending against threats to the health of the residents of this state;

32 (3) Protecting individuals from the financial consequences of ill health;

33 (4) Providing equitable access to person-centered care;

34 (5) Removing cost as a barrier to accessing health care;

35 (6) Removing any financial incentive for a health care practitioner to provide care to one
36 patient rather than another;

37 (7) Making it possible for individuals to participate in decisions affecting their health and
38 the health system;

39 (8) Establishing measurable health care goals and guidelines that align with other state
40 and federal health standards; and

41 (9) Promoting continuous quality improvement and fostering interorganizational collab-
42 oration.

43 **SECTION 3. Values.** The Universal Health Care Commission, in making recommendations
44 for the Health Care for All Oregon Plan, shall consider, at a minimum, the following values:

45 (1) Health care, as a fundamental element of a just society, is to be secured for all indi-

1 individuals on an equitable basis by public means, similar to public education, public safety and
2 other public infrastructure;

3 (2) Access to a distribution of health care resources and services according to each
4 individual's needs and location within the state should be available. Race, color, national or-
5 igin, age, disability, wealth, income, citizenship status, primary language use, genetic condi-
6 tions, previous or existing medical conditions, religion or sex, including sex stereotyping,
7 gender identity, sexual orientation and pregnancy and related medical conditions, including
8 termination of pregnancy, may not create any barriers to health care nor disparities in
9 health outcomes due to access to care;

10 (3) The components of the system will be accountable and fully transparent to the public
11 with regard to information, decision-making and management through meaningful public
12 participation in decisions affecting people's health care; and

13 (4) Funding for the Health Care for All Oregon Plan is a public trust and any savings or
14 excess revenue are to be returned to that public trust.

15 **SECTION 4. Principles.** The Universal Health Care Commission, in making recommen-
16 dations for the Health Care for All Oregon Plan, shall consider at a minimum the following
17 principles:

18 (1) Participants in the Health Care for All Oregon Plan may choose any health care pro-
19 vider or prepaid group practice with salaried providers who are licensed, certified or regis-
20 tered in this state, without requiring prior approval.

21 (2) The plan may not discriminate against any health care provider who provides services
22 covered by the plan and is licensed, certified or registered in this state and who is acting
23 within the provider's scope of practice.

24 (3) Within the scope of services covered within each category, and within the parameters
25 of standard of care for the plan, participants and their health care providers shall determine
26 whether a treatment is medically necessary or medically appropriate for that participant.

27 (4) The plan will cover services from birth to death based on evidence-informed decisions
28 as determined by the Health Care for All Oregon Board.

29 **SECTION 5. Scope of the Universal Health Care Commission.** (1) The design of the Health
30 Care for All Oregon Plan by the Universal Health Care Commission must:

31 (a) Be based on a single payer health care financing system; and

32 (b) Assume that the state will have the ability to waive restrictions that interfere with
33 residents who have other coverage enrolling in the Health Care for All Oregon Plan without
34 jeopardizing their eligibility for the other coverage, so that they can continue to access some
35 services through the other coverage, if they desire, or resume the other coverage if they
36 move out of this state. Such other coverage includes but is not limited to:

37 (A) Medicaid;

38 (B) Medicare;

39 (C) The Children's Health Insurance Program;

40 (D) The Federal Employees Health Benefit Program;

41 (E) TRICARE;

42 (F) Self-insured health insurance plans;

43 (G) Multiple employer welfare arrangements, as defined in ORS 750.301;

44 (H) The United States Department of Veterans Affairs Veterans Health Administration;

45 or

1 **(1) The Indian Health Service.**

2 **(2) The design of the plan must follow the values and principles described in sections 3**
3 **and 4 of this 2019 Act. In designing the plan, the commission shall consider:**

4 **(a) How the plan will impact the structure of existing state and local boards and com-**
5 **missions, county, city, and special service districts, as well as the United States Government,**
6 **other states and Indian tribes; and**

7 **(b) The issues raised in the report entitled “A Comprehensive Assessment of Four**
8 **Options for Financing Health Care Delivery in Oregon” produced in response to section 1,**
9 **chapter 712, Oregon Laws 2013, and section 2, chapter 725, Oregon Laws 2015.**

10 **(3) The commission shall make findings and recommendations and submit a report of its**
11 **findings and recommendations for the design of the plan to the Legislative Assembly as**
12 **provided in ORS 192.245. The report must include, but is not limited to, the following:**

13 **(a) The governance and leadership of the Health Care for All Oregon Board, specifically:**

14 **(A) The composition and representation of the membership of the board appointed or**
15 **otherwise selected using an open and equitable selection process;**

16 **(B) The statutory authority the board must have to establish policies, guidelines, man-**
17 **dates, incentives and enforcement needed to develop a highly effective and responsive health**
18 **care system;**

19 **(C) The ethical standards and the enforcement of the ethical standards for members of**
20 **the board such that there are the most rigorous protections and prohibitions from actual**
21 **or perceived economic conflicts of interest; and**

22 **(D) Ensuring that there is no disproportionate influence by any individual, organization,**
23 **government, industry, business or profession in any decision-making by the board;**

24 **(b) A list of federal and state laws, rules, state contracts or agreements, court actions**
25 **or decisions that may facilitate, constrain, or prevent implementation of the plan and an**
26 **explanation of how the federal or state laws, rules, state contracts or agreements, court**
27 **actions or decision may facilitate or constrain or prevent implementation;**

28 **(c) Coverage for nonresidents who receive services but are not eligible for the plan;**

29 **(d) The plan’s economic sustainability, operational efficiency and cost control measures**
30 **that include, but are not limited to the following:**

31 **(A) A financing governance system supported by relevant legislation, financial audit and**
32 **public expenditure reviews and clear operational rules to ensure efficient use of public funds;**
33 **and**

34 **(B) Cost control features such as multistate purchasing;**

35 **(e) Estimates of the savings and expenditure increases under the plan relative to the**
36 **current health care system, including but not limited to:**

37 **(A) The elimination of waste in the current system and savings from administrative**
38 **simplification, fraud reduction, monopsony power, simplification of electronic documentation**
39 **and other savings that the commission identifies;**

40 **(B) Savings by eliminating the cost of insurance that provides medical benefits that**
41 **would now be provided through the plan; and**

42 **(C) The increased costs to provide better health care to more individuals than under the**
43 **current health care system;**

44 **(f) Estimates of the expected health care expenditures under the plan compared to the**
45 **current health care system, reported in categories similar to the National Health Expendi-**

1 **ture Accounts compiled by the Centers for Medicare and Medicaid Services, including, at a**
2 **minimum:**

3 **(A) Personal health care expenditures;**

4 **(B) Health consumption expenditures; and**

5 **(C) State health expenditures;**

6 **(g) Features of the plan that are necessary to continue to receive federal funding that**
7 **is currently available to the state and estimates of the amount of the federal funding that**
8 **will be available;**

9 **(h) Estimates of how much of the expenditures on the plan will be made from funds al-**
10 **ready spent on health care in this state from both state and federal sources and redirected**
11 **or utilized, in an equitable and comprehensive manner, to the plan;**

12 **(i) Estimates of how much, if any, additional state revenue will be required;**

13 **(j) Fiduciary requirements for the revenue generated to fund the plan including, but not**
14 **limited to, the following:**

15 **(A) A dedicated fund separate and distinct from the General Fund that is held in trust**
16 **for the residents of this state;**

17 **(B) Restrictions to be authorized by the Health Care for All Oregon Board on the use of**
18 **the trust fund;**

19 **(C) A process for creating a reserve fund by retaining funds in the trust fund if, during**
20 **a year, revenue exceeds costs; and**

21 **(D) Required accounting methods that eliminate the potential for misuse of public funds,**
22 **detect inaccuracies in provider reimbursement and use the most rigorous generally accepted**
23 **accounting principles, including annual external audits and audits at the time of each tran-**
24 **sition in the board's executive management;**

25 **(k) Requirements for the purchase of reinsurance;**

26 **(L) Bonding authority that may be necessary;**

27 **(m) The role of the Health Care for All Oregon Board's role in workforce recruitment,**
28 **retention and development, including but not limited to the following:**

29 **(A) Using the Health Care Provider Incentive Fund established in ORS 676.450;**

30 **(B) Achieving workforce adequacy, having a sufficient number and mix of healthcare**
31 **professionals, including a diversity of providers and a range of competencies;**

32 **(C) Developing provider reimbursement methodologies that are effective in recruiting and**
33 **retaining an adequate health care workforce; and**

34 **(D) Providing continuous professional education and making changes or recommen-**
35 **dations in the scope of practice related to professional licensure;**

36 **(n) A process for the board to develop statewide goals, objectives and ongoing review;**

37 **(o) The appropriate relationship between the board and regional or local authorities and**
38 **oversight of health activities, health care systems and providers to promote community**
39 **health reinvestment, equity and accountability;**

40 **(p) Criteria to guide the board in determining which health care services are necessary**
41 **for the maintenance of health, the prevention of health problems, the treatment or rehabil-**
42 **itation of health conditions and long term and respite care. Guidelines may include, but are**
43 **not limited to, the following:**

44 **(A) Whether the services are cost-effective and evidence-based from multiple sources of**
45 **evidence;**

1 (B) Whether the services are currently covered by the health benefit plans offered by the
2 Oregon Educators Benefit Board and the Public Employees' Benefit Board;

3 (C) Whether the services are designated as effective by the United States Preventive
4 Services Task Force, the Advisory Committee on Immunization Practices, the Health Re-
5 sources and Services Administration's Bright Futures project, the Institute of Medicine
6 Committee on Preventive Services for Women or the Health Evidence Review Commission;

7 (D) Whether the evidence on the effectiveness of services comes from peer reviewed
8 medical literature, existing assessments and recommendations from state and federal boards
9 and commissions and other peer reviewed sources; and

10 (E) Whether the services are based on information provided by the Traditional Health
11 Workers Commission established in ORS 413.600; and

12 (g) How the plan will track and resolve complaints, grievances, and appeals, including
13 establishing an Office of the Patient Advocate.

14 (4)(a) The Universal Health Care Commission's recommendations and findings regarding
15 revenue for the plan, including redirecting existing health care expenditures, under sub-
16 section (3)(h) of this section, must be ranked according to explicit criteria, including the
17 degree to which an individual, class of individuals or organization would experience an in-
18 crease, decrease or no change in the direct or indirect financial burden. Revenue options
19 may include, but are not limited to, the following:

20 (A) Redirecting current expenditures by public agencies;

21 (B) An employer payroll tax based on progressive principles that protect small businesses
22 and that tend to preserve or enhance federal tax expenditures for Oregon employers that pay
23 the costs of their employees' health care; and

24 (C) A dedicated revenue stream based on progressive taxes that do not impose a burden
25 on individuals who would otherwise qualify for medical assistance.

26 (b) Revenue options may not include deductibles, copayments, coinsurance or any other
27 out-of-pocket expenses imposed on plan participants.

28 (5) The commission shall explore the effect of means-tested copayments or deductibles,
29 comparing versions of the plan with and without means-tested copayments or deductibles,
30 including but not limited to the effect of increased administrative complexity and the re-
31 sulting costs that cause patients to delay getting necessary care, resulting in more severe
32 consequences for their health.

33 (6) The commission's recommendations must ensure:

34 (a) Public access to state, regional and local reports and forecasts of revenue expen-
35 ditures;

36 (b) That the reports and forecasts are accurate, timely, of sufficient detail and presented
37 in a way that is understandable to the public to inform policymaking and the allocation or
38 reallocation of public resources; and

39 (c) That the information can be used to evaluate programs and policies, while protecting
40 patient confidentiality.

41 (7) The commission shall:

42 (a) Study other states' attempts at providing universal coverage and using single payer
43 health care financing systems, including the outcomes of the attempts.

44 (b) Present options for transition planning, including an impact analysis on existing
45 health systems, providers and patient relationships.

1 (c) Evaluate the impact on individuals, communities and the state if the current level of
2 health care spending continues, using existing reports and analysis where available.

3 (8) In establishing the criteria to guide the board in determining the health services to
4 be covered by the plan under subsection (3)(p) of this section, the commission shall:

5 (a) Ensure input from individuals in rural and underserved communities and from indi-
6 viduals in communities that experience health care disparities;

7 (b) Solicit public comments statewide while providing the public evidence-based informa-
8 tion developed by the commission about the health care costs of a single payer health care
9 financing system as compared to the current system;

10 (c) Solicit the perspectives of:

11 (A) Individuals throughout the range of communities that experience health care dis-
12 parities;

13 (B) A range of businesses based on industry and employer size;

14 (C) Individuals with a range of current insurance types and those who are uninsured or
15 underinsured; and

16 (D) Individuals with a range of health care needs including individuals needing disability
17 services and long term care services; and

18 (d) Preserve the coverage of the health services currently required by Medicare,
19 Medicaid, the Children's Health Insurance Program, the Patient Protection and Affordable
20 Care Act (P.L.111-148), as amended by the Health Care and Education Reconciliation Act of
21 2010 (P.L.111-152), Oregon's medical assistance program and by any other state or federal
22 program.

23 (9) The commission's recommendations must be succinct statements and include actions
24 and timelines, the degree of consensus and the priority of each recommendation based on
25 urgency and importance. The commission may also defer any recommendations for the
26 Health Care for All Oregon Board to determine.

27 (10) The commission, in developing and reporting to the Legislative Assembly its findings
28 and recommendations, shall describe how the board or some other entity may enhance:

29 (a) Access to comprehensive, high quality, patient-centered, patient-empowered, equitable
30 and publicly funded health care for all individuals;

31 (b) Financially sustainable and cost-effective health care for the benefit of businesses,
32 families, individuals and state and local governments;

33 (c) Regional and community-based systems integrated with community programs to
34 contribute to the health of individuals and communities;

35 (d) Regional planning for cost-effective, reasonable capital expenditures that promote
36 regional equity;

37 (e) Funding for the modernization of public health, under ORS 431.001 to 431.550, as an
38 integral component of cost efficiency in an integrated health care system; and

39 (f) An ongoing and deepening collaboration with Indian tribes and other organizations
40 providing health care that will not be under the authority of the board.

41 (11) After reviewing the work from existing health care professional boards and com-
42 missions, the Universal Health Care Commission shall incorporate important aspects of the
43 work of the health care professional boards and commissions into recommendations for the
44 plan.

45 **SECTION 6. General Nature of the System to be Evaluated.** (1) The Health Care for All

1 Oregon Plan designed by the Universal Health Care Commission shall allow participation by
2 any individual who:

3 (a) Resides in this state;

4 (b) Is a nonresident who works full time in this state and contributes to the plan; or

5 (c) Is a nonresident who is a dependent of an individual described in paragraph (a) or (b)
6 of this subsection.

7 (2) Risk-bearing entities may not be permitted to operate as a conduit between the plan
8 and health care providers.

9 (3) Health care providers shall be paid as follows:

10 (a) The payment options for physicians and other individual health practitioners licensed
11 in this state will be:

12 (A) Fee-for-service reimbursement for services;

13 (B) Salaries for practitioners in institutions that are reimbursed with global budgets; and

14 (C) Salaries for practitioners in group practices or health care service contractors that
15 are reimbursed by capitation payments.

16 (b) The commission shall recommend reimbursement to be paid to out-of-state providers
17 for health services provided to plan participants if the services are provided out of medical
18 necessity or because the services were reasonably accessible only out of state.

19 (c) Except as provided in paragraph (d) of this subsection, institutional providers will be
20 paid by global budgets.

21 (d) An institutional provider may receive capitation payments if the provider:

22 (A) Is a nonprofit;

23 (B) Delivers care in the institution using salaried practitioners who are employees;

24 (C) Does not use the capitated payments for hospital services; and

25 (D) Does not offer financial incentives based on utilization of services.

26 (4) Large institutional providers of inpatient care shall be paid with a global budget con-
27 sisting of separate operational and capital budgets. Regional planning must determine ap-
28 propriate capital budgets. The commission shall make recommendations regarding how to
29 define a large institutional provider, how it shall be determined and the principles guiding the
30 determination. Global budgets for hospitals must apply to individual hospitals, not to entities
31 that own hospitals, clinics and other providers of medical goods and services.

32 (5) The commission shall estimate hospital administrative savings that are expected in a
33 system in which hospitals are paid as described in subsections (3) and (4) of this section.

34 (6) The commission shall estimate costs of and new public revenue required for the plan
35 with and without long term care included. A plan that includes long term care must assume
36 that long term services and supports will be tailored to the individual's needs based on an
37 assessment and include:

38 (a) Long term nursing services in an institution or a community-based setting;

39 (b) A broad spectrum of long term services and supports including home and
40 community-based settings or other noninstitutional settings;

41 (c) Services that meet the physical, mental and social needs of individuals while allowing
42 them their maximum possible autonomy and maximum civic, social and economic partic-
43 ipation;

44 (d) Long term services and supports regardless of the individual's type of disability, level
45 of disability, service needs or age;

1 (e) Services provided in the least restrictive setting appropriate to the individual's needs;
2 (f) Services provided in a manner that allows persons with disabilities to maintain their
3 independence, self-determination and dignity;

4 (g) Services and supports that are of equal quality and accessibility in every geographic
5 region of this state; and

6 (h) Services and supports that give the individual the opportunity to direct the services.

7 (7) In developing the plan that includes long term care the commission shall convene an
8 advisory committee that includes:

9 (a) Persons with disabilities who receive long term services and supports;

10 (b) Older adults who receive long term services and supports;

11 (c) Individuals representing persons with disabilities and older adults;

12 (d) Members of groups that represent the diversity of individuals who have disabilities
13 including by gender, race and economic status;

14 (e) Providers of long term services and supports, including family attendants, family
15 caregivers and in-home care providers who are represented by organized labor; and

16 (f) Academics and researchers in relevant fields of study.

17 (8) The commission's recommendations for the duties of the Health Care for All Oregon
18 Board and the details of the Health Care for All Oregon Plan must ensure that patients are
19 empowered to protect their health, their rights and their privacy by considering the follow-
20 ing:

21 (a) Access to patient advocates who are responsible to the patient and maintain patient
22 confidentiality and whose responsibilities include but are not limited to addressing concerns
23 about providers and helping patients navigate the process of obtaining medical care;

24 (b) Access to culturally and linguistically appropriate care and service;

25 (c) The patient's ability to obtain needed care when a treating provider or institution is
26 unable or unwilling to provide the care;

27 (d) Paying providers for completing forms or performing other administrative functions
28 to assist patients in qualifying for disability benefits, family medical leave or other income
29 supports; and

30 (e) The patient's access to and control of medical records, including:

31 (A) Empowering patients to control access to their medical records and obtain inde-
32 pendent second opinions, unless there are clear medical reasons not to do so;

33 (B) Requiring that a patient or the patient's designee be provided a complete copy of the
34 patient's health records promptly after every interaction or visit with a health care provider;

35 (C) Ensuring that the copy of the health records provided to a patient includes all data
36 used in the care of that patient; and

37 (D) Requiring that the patient or the patient's designee approve the forwarding to or
38 access by family members, caregivers, other providers and researchers of the patient's data.

39 **SECTION 7. Commission Timeline.** (1) The Universal Health Care Commission shall have
40 its first meeting no later than November 1, 2019.

41 (2) No later than March 15, 2020, the commission shall provide an interim report to the
42 interim committees of the Legislative Assembly related to health on the progress of the
43 commission in preparing the recommendations for the Health Care for All Oregon Plan and
44 the Health Care for All Oregon Board.

45 (3) No later than February 1, 2021, the commission shall submit its final findings and

1 recommendations for the design of the Health Care for All Oregon Plan and the Health Care
2 for All Oregon Board to the committees of the Legislative Assembly related to health.

3 (4) If the recommendations are not complete by February 1, 2021, the commission shall
4 report to the committees of the Legislative Assembly related to health the work that re-
5 mains and timeline for completion.

6 SECTION 8. Captions. The section captions used in this 2019 Act are provided only for
7 the convenience of the reader and do not become part of the statutory law of this state or
8 express any legislative intent in the enactment of this 2019 Act.

9 SECTION 9. Emergency clause. This 2019 Act being necessary for the immediate preser-
10 vation of the public peace, health and safety, an emergency is declared to exist, and this 2019
11 Act takes effect on its passage.

12