

Senate Bill 1551

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced**.

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

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

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

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

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

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to health care; creating new provisions; amending ORS 414.591, 414.611 and 743A.001 and
3 sections 8 and 10, chapter 629, Oregon Laws 2019; and declaring an emergency.

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

5 **SECTION 1. (1) As used in this section, "coordinated care organization" has the meaning**
6 **given that term in ORS 414.025.**

7 **(2) The Oregon Health Authority shall report to the committees of the Legislative As-**
8 **sembly related to health, in the manner provided in ORS 192.245, any of the following that**
9 **occurred in the preceding six-month period:**

10 **(a) Any civil penalty imposed on a coordinated care organization under ORS 414.591,**
11 **415.063 or 415.109 and the basis for the penalty;**

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

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

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

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

23 **(4) With respect to the reporting of corrective actions under subsection (1)(b) of this**

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 **section, if a coordinated care organization has not undertaken corrective action in time for**
 2 **the next report due, the authority shall report the action in the report due after the action**
 3 **is undertaken.**

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

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

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

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

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

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

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

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

23 **SECTION 5.** ORS 414.591 is amended to read:

24 414.591. (1) The Oregon Health Authority shall use, to the greatest extent possible, coordinated
 25 care organizations to provide fully integrated physical health services, chemical dependency and
 26 mental health services and oral health services. This section, and any contract entered into pur-
 27 suant to this section, does not affect and may not alter the delivery of Medicaid-funded long term
 28 care services.

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

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

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

38 (B) Include information on the three highest executive salary and benefit packages of each co-
 39 ordinated care organization;

40 (C) Require quarterly reports to be filed with the authority by May 31, August 31 and November
 41 30;

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

45 (E) Align, to the greatest extent practicable, with the National Association of Insurance

1 Commissioners' reporting forms to reduce the administrative costs of coordinated care organizations
2 that are also regulated by the Department of Consumer and Business Services or have affiliates that
3 are regulated by the department.

4 (b) The authority shall provide information to coordinated care organizations about the report-
5 ing standards of the National Association of Insurance Commissioners and provide training on the
6 reporting standards to the staff of coordinated care organizations who will be responsible for com-
7 piling the reports.

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

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

15 (5) The authority shall require compliance with the provisions of subsections (3) and (4) of this
16 section as a condition of entering into a contract with a coordinated care organization. A coordi-
17 nated care organization, contractor or provider that fails to comply with subsection (3) or (4) of this
18 section may be subject to sanctions, including but not limited to civil penalties, barring any new
19 enrollment in the coordinated care organization and termination of the contract.

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

28 (b) "Rural health clinic," as used in this subsection, shall be defined by the authority by rule
29 and shall conform, as far as practicable or applicable in this state, to the definition of that term in
30 42 U.S.C. 1395x(aa)(2).

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

36 (8) The aggregate expenditures by the authority for health services provided pursuant to this
37 chapter may not exceed the total dollars appropriated for health services under this chapter.

38 (9) Actions taken by providers, potential providers, contractors and bidders in specific accord-
39 ance with this chapter in forming consortiums or in otherwise entering into contracts to provide
40 health care services shall be performed pursuant to state supervision and shall be considered to be
41 conducted at the direction of this state, shall be considered to be lawful trade practices and may
42 not be considered to be the transaction of insurance for purposes of the Insurance Code.

43 (10) Health care providers contracting to provide services under this chapter shall advise a pa-
44 tient of any service, treatment or test that is medically necessary but not covered under the con-
45 tract if an ordinarily careful practitioner in the same or similar community would do so under the

1 same or similar circumstances.

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

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

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

10 (a) Grievances and appeals; and

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

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

14 **SECTION 6.** ORS 414.611 is amended to read:

15 414.611. (1) The Oregon Health Authority may approve *[the]* **a coordinated care organization's**
16 **request to** transfer *[of]* 500 or more members from one coordinated care organization to *[another]*
17 **the requesting** coordinated care organization if:

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

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

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

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

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

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

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

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

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

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

42 (6) **The authority may not involuntarily transfer a member who is enrolled in a coordi-**
43 **nated care organization serving the area where the member lives to any other coordinated**
44 **care organization prior to the redetermination of the member's eligibility for medical as-**
45 **sistance under ORS 411.406 unless:**

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

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

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

6 743A.001. (1) Except as provided in subsection (4) of this section, any statute described in sub-
7 section (2) of this section that becomes effective on or after July 13, 1985, is repealed on the sixth
8 anniversary of the effective date of the statute, unless the Legislative Assembly specifically provides
9 otherwise.

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

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

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

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

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

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

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

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

25 (4) This section does not apply to ORS 743A.020, 743A.080, 743A.100, 743A.104, [and] 743A.108,
26 **743A.124 and 743A.180, or any statute described in subsection (2) of this section that requires**
27 **coverage or reimbursement of an essential health benefit.**

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

29 **SECTION 9. This 2020 Act being necessary for the immediate preservation of the public**
30 **peace, health and safety, an emergency is declared to exist, and this 2020 Act takes effect**
31 **on its passage.**

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