

House Bill 2473

Sponsored by Representative RESCHKE; Representatives BONHAM, NEARMAN, ZIKA (Presession filed.)

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**.

Modifies conditions of eligibility for tax credit allowed to rural medical care provider. Removes eligibility limitation on adjusted gross income of individual providing rural medical care, restrictions on types of hospitals and tiered amounts of allowable credit based on distance from certain municipalities.

Applies to tax years beginning on or after January 1, 2022.

Extends sunset for credit.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

1
2 Relating to a tax credit for rural medical care; creating new provisions; amending ORS 243.256,
3 243.879, 315.613, 315.616 and 442.563 and section 25, chapter 913, Oregon Laws 2009; and pre-
4 scribing an effective date.

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

6 **SECTION 1.** ORS 315.613 is amended to read:

7 315.613. (1) **As used in this section, "rural community" means a community that is at**
8 **least 20 highway miles from any municipality with a population of 50,000 or more.**

9 [(1)] (2) An annual credit against the taxes otherwise due under ORS chapter 316 shall be al-
10 lowed to a resident or nonresident individual who is:

11 (a) Certified as eligible under ORS 442.563;

12 (b) Licensed under ORS chapter 677; **and**

13 (c) Engaged in the practice of medicine, and engaged for at least 20 hours per week, averaged
14 over the month, during the tax year in a rural practice[; *and*].

15 [(d) *Has adjusted gross income not in excess of \$300,000 for the tax year. The limitation in this*
16 *paragraph does not apply to a physician who practices as a general surgeon, specializes in obstetrics*
17 *or specializes in family or general practice and provides obstetrical services.*]

18 [(2) *The amount of credit allowed shall be based on the distance from a major population center*
19 *in a qualified metropolitan statistical area at which the taxpayer maintains a practice or hospital*
20 *membership:*]

21 [(a) *If at least 10 miles but fewer than 20 miles, \$3,000.*]

22 [(b) *If at least 20 miles but fewer than 50 miles, \$4,000.*]

23 [(c) *If 50 or more miles, \$5,000.*]

24 **(3) The amount of credit allowed under this section shall be \$5,000.**

25 [(3)] (4) The credit shall be allowed during the time in which the individual retains [*such*] **a**
26 practice and **hospital** membership if the individual is actively practicing in and is a member of the
27 medical staff of [*one of the following hospitals:*] **a hospital located in a rural community.**

28 [(a) *A type A hospital designated as such by the Office of Rural Health;*]

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 **[(b) A type B hospital designated as such by the Office of Rural Health if the hospital is:]**

2 **[(A) Not within the boundaries of a metropolitan statistical area;]**

3 **[(B) Located 30 or more miles from the closest hospital within the major population center in a**
 4 **metropolitan statistical area; or]**

5 **[(C) Located in a county with a population of less than 75,000;]**

6 **[(c) A type C rural hospital, if the Office of Rural Health makes the findings required by ORS**
 7 **315.619;]**

8 **[(d) A rural critical access hospital; or]**

9 **[(e) A hospital:]**

10 **[(A) Classified by the Centers for Medicare and Medicaid Services as a rural referral center in**
 11 **accordance with 42 U.S.C. 1395ww(d)(5)(C)(i); and]**

12 **[(B) Classified by the Centers for Medicare and Medicaid Services as a sole community hospital**
 13 **in accordance with 42 U.S.C. 1395ww(d)(5)(D)(iii).]**

14 **[(4) (5) In order to claim the credit allowed under this section, the individual must remain**
 15 **willing during the tax year to serve patients with Medicare coverage and patients receiving medical**
 16 **assistance in at least the same proportion to the individual’s total number of patients as the Medi-**
 17 **care and medical assistance populations represent of the total number of persons determined by the**
 18 **Office of Rural Health to be in need of care in the county served by the practice, not to exceed 20**
 19 **percent Medicare patients or 15 percent medical assistance patients.**

20 **[(5) (6) A nonresident individual shall be allowed the credit under this section in the proportion**
 21 **provided in ORS 316.117. If a change in the status of a taxpayer from resident to nonresident or from**
 22 **nonresident to resident occurs, the credit allowed by this section shall be determined in a manner**
 23 **consistent with ORS 316.117.**

24 **[(6) (7) For purposes of this section, an “individual’s practice” shall be determined on the basis**
 25 **of actual time spent in practice each week in hours or days, whichever is considered by the Office**
 26 **of Rural Health to be more appropriate. In the case of a shareholder of a corporation or a member**
 27 **of a partnership, only the time of the individual shareholder or partner shall be considered and the**
 28 **full amount of the credit shall be allowed to each shareholder or partner who qualifies in an indi-**
 29 **vidual capacity.**

30 **[(7) As used in this section:]**

31 **[(a) “Qualified metropolitan statistical area” means only those counties of a metropolitan statistical**
 32 **area that are located in Oregon if the largest city within the metropolitan statistical area is located in**
 33 **Oregon.]**

34 **[(b) “Rural critical access hospital” means a facility that meets the criteria set forth in 42 U.S.C.**
 35 **1395i-4 (c)(2)(B) and that has been designated a critical access hospital by the Office of Rural Health**
 36 **and the Oregon Health Authority.]**

37 **[(c) “Type A hospital,” “type B hospital” and “type C hospital” have the meaning for those terms**
 38 **provided in ORS 442.470.]**

39 **SECTION 2. ORS 315.616 is amended to read:**

40 **315.616. A resident or nonresident individual who is certified as eligible under ORS 442.561,**
 41 **442.562, 442.563 or 442.564, and is licensed as a physician under ORS chapter 677, licensed as a**
 42 **physician assistant under ORS chapter 677, licensed as a nurse practitioner under ORS chapter 678,**
 43 **licensed as a certified registered nurse anesthetist under ORS chapter 678, licensed as a dentist**
 44 **under ORS chapter 679 or licensed as an optometrist under ORS 683.010 to 683.340 is entitled to the**
 45 **tax credit described in ORS 315.613 even if not a member of the hospital medical staff if the Office**

1 of Rural Health certifies that the individual:

2 (1) Is engaged for at least 20 hours per week, averaged over the month, during the tax year in
3 a rural practice; and

4 (2)(a) If a physician or a physician assistant, can cause a patient to be admitted to the hospital;

5 (b) If a certified registered nurse anesthetist, is employed by or has a contractual relationship
6 with *[one of the hospitals described]* **a hospital located in a rural community as defined** in ORS
7 315.613 (1); or

8 (c) If an optometrist, has consulting privileges with a hospital *[listed]* **located in a rural com-**
9 **munity as defined** in ORS 315.613 (1). This paragraph does not apply to an optometrist who quali-
10 fies as a “frontier rural practitioner,” as defined by the Office of Rural Health.

11 **SECTION 3.** ORS 442.563 is amended to read:

12 442.563. *[(1)]* The Office of Rural Health shall establish criteria for certifying individuals eligible
13 for the tax credit authorized by ORS 315.613. Upon application therefor, the office shall certify in-
14 dividuals eligible for the tax credit authorized by ORS 315.613.

15 *[(2) The classification of rural hospitals described in ORS 315.613 (3)(a) to (d) for purposes of de-*
16 *termining eligibility under this section shall be the classification of the hospital in effect on January*
17 *1, 1991.]*

18 **SECTION 4.** Section 25, chapter 913, Oregon Laws 2009, as amended by section 10, chapter 750,
19 Oregon Laws 2013, section 18, chapter 701, Oregon Laws 2015, section 7, chapter 829, Oregon Laws
20 2015, and section 13, chapter 610, Oregon Laws 2017, is amended to read:

21 **Sec. 25.** (1) Except as provided in subsection (2) of this section, a credit may not be claimed
22 under ORS 315.613 for tax years beginning on or after January 1, *[2022]* **2028**.

23 (2) A taxpayer who meets the eligibility requirements in ORS 315.613 for the tax year beginning
24 on or after January 1, 2021, and before January 1, *[2022]* **2026**, shall be allowed the credit under
25 ORS 315.613 for any tax year:

26 (a) That begins on or before January 1, *[2031]* **2037**; and

27 (b) For which the taxpayer meets the eligibility requirements of ORS 315.613.

28 (3) Notwithstanding subsection (2) of this section, a taxpayer may not during the taxpayer’s
29 lifetime claim the credit allowed under this section for more than a total of 10 tax years that begin
30 on or after January 1, 2018.

31 **SECTION 5. The amendments to ORS 315.613, 315.616 and 442.563 by sections 1 to 3 of this**
32 **2021 Act apply to tax years beginning on or after January 1, 2022.**

33 **SECTION 6.** ORS 243.256 is amended to read:

34 243.256. (1) A carrier that contracts with the Public Employees’ Benefit Board to provide to el-
35 igible employees and their dependents a benefit plan that reimburses the cost of inpatient or out-
36 patient hospital services or supplies shall reimburse a claim for the cost of a hospital service or
37 supply that is covered by, or is similar to a service or supply that is covered by, the Medicare
38 program in an amount that does not exceed:

39 (a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare
40 for the service or supply; or

41 (b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medi-
42 care for the service or supply.

43 (2) A self-insurance program administered by a third party administrator that is offered by the
44 board to eligible employees and their dependents and that reimburses the cost of inpatient or out-
45 patient hospital services or supplies shall reimburse a claim for the cost of a hospital service or

1 supply that is covered by, or is similar to a service or supply that is covered by, the Medicare
 2 program in an amount that does not exceed:

3 (a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare
 4 for the service or supply; or

5 (b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medi-
 6 care for the service or supply.

7 (3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section may
 8 not charge to or collect from the patient or a person who is financially responsible for the patient
 9 an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other
 10 than cost sharing amounts authorized by the terms of the health benefit plan.

11 (4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis,
 12 the payment method used must take into account the limits specified in subsections (1) and (2) of this
 13 section. Such payment methods include, but are not limited to:

14 (a) Value-based payments;

15 (b) Capitation payments; and

16 (c) Bundled payments.

17 (5) This section does not apply to reimbursements paid by a carrier or third party administrator
 18 to:

19 (a) A type A or type B hospital as described in ORS 442.470;

20 (b) A rural critical access hospital [*as defined in ORS 315.613*];

21 (c) A hospital:

22 (A) Located in a county with a population of less than 70,000 on August 15, 2017;

23 (B) Classified as a sole community hospital by the Centers for Medicare and Medicaid Services;
 24 and

25 (C) With Medicare payments composing at least 40 percent of the hospital's total annual patient
 26 revenue; or

27 (d) A hospital located outside of this state.

28 (6) This section does not require a health benefit plan offered by the board to reimburse claims
 29 using a fee-for-service payment method.

30 **(7) As used in this section, "rural critical access hospital" means a facility that meets**
 31 **the criteria set forth in 42 U.S.C. 1395i-4 (c)(2)(B) and that has been designated a critical**
 32 **access hospital by the Office of Rural Health and the Oregon Health Authority.**

33 **SECTION 7.** ORS 243.879 is amended to read:

34 243.879. (1) A carrier that contracts with the Oregon Educators Benefit Board to provide to el-
 35 igible employees and their dependents a benefit plan that reimburses the cost of inpatient or out-
 36 patient hospital services or supplies shall reimburse a claim for the cost of a hospital service or
 37 supply that is covered by, or is similar to a service or supply that is covered by, the Medicare
 38 program in an amount that does not exceed:

39 (a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare
 40 for the service or supply; or

41 (b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medi-
 42 care for the service or supply.

43 (2) A self-insurance program administered by a third party administrator that is offered by the
 44 board to eligible employees and their dependents and that reimburses the cost of inpatient or out-
 45 patient hospital services or supplies shall reimburse a claim for the cost of a hospital service or

1 supply that is covered by, or is similar to a service or supply that is covered by, the Medicare
2 program in an amount that does not exceed:

3 (a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare
4 for the service or supply; or

5 (b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medi-
6 care for the service or supply.

7 (3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section may
8 not charge to or collect from the patient or a person who is financially responsible for the patient
9 an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other
10 than cost sharing amounts authorized by the terms of the health benefit plan.

11 (4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis,
12 the payment method used must take into account the limits specified in subsections (1) and (2) of this
13 section. Such payment methods include, but are not limited to:

14 (a) Value-based payments;

15 (b) Capitation payments; and

16 (c) Bundled payments.

17 (5) This section does not apply to reimbursements paid by a carrier or third party administrator
18 to:

19 (a) A type A or type B hospital as described in ORS 442.470;

20 (b) A rural critical access hospital [*as defined in ORS 315.613*];

21 (c) A hospital:

22 (A) Located in a county with a population of less than 70,000 on August 15, 2017;

23 (B) Classified as a sole community hospital by the Centers for Medicare and Medicaid Services;
24 and

25 (C) With Medicare payments composing at least 40 percent of the hospital's total annual patient
26 revenue; or

27 (d) A hospital located outside of this state.

28 (6) This section does not require a health benefit plan offered by the board to reimburse claims
29 using a fee-for-service payment method.

30 (7) **As used in this section, "rural critical access hospital" means a facility that meets**
31 **the criteria set forth in 42 U.S.C. 1395i-4 (c)(2)(B) and that has been designated a critical**
32 **access hospital by the Office of Rural Health and the Oregon Health Authority.**

33 **SECTION 8. This 2021 Act takes effect on the 91st day after the date on which the 2021**
34 **regular session of the Eighty-first Legislative Assembly adjourns sine die.**

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