

House Bill 2085

Sponsored by Representative JAVADI; Representative REYNOLDS (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**.

Changes name of Health Care Cost Growth Target program to Premium Cost Growth Target program. Restricts scope of program to reducing growth in premium costs.

A BILL FOR AN ACT

1
2 Relating to premium costs; amending ORS 415.500, 415.501, 442.385, 442.386 and 442.993 and section
3 7, chapter 51, Oregon Laws 2021.

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

5 **SECTION 1.** ORS 442.385 is amended to read:

6 442.385. As used in this section and ORS 442.386:

7 (1) "Health care" means items, services and supplies intended to improve or maintain human
8 function or treat or ameliorate pain, disease, condition or injury, including but not limited to the
9 following types of services:

10 (a) Medical;

11 (b) Behavioral;

12 (c) Substance use disorder;

13 (d) Mental health;

14 (e) Surgical;

15 (f) Optometric;

16 (g) Dental;

17 (h) Podiatric;

18 (i) Chiropractic;

19 (j) Psychiatric;

20 (k) Pharmaceutical;

21 (L) Therapeutic;

22 (m) Preventive;

23 (n) Rehabilitative;

24 (o) Supportive; or

25 (p) Geriatric.

26 [(2) "Health care cost growth" means the annual percentage change in total health expenditures in
27 this state.]

28 [(3) "Health care entity" means a payer or a provider.]

29 [(4) "Health insurance" has the meaning given that term in ORS 731.162.]

30 [(5) "Net cost of private health insurance" means the difference between health insurance premiums
31 received by a payer and the claims for the cost of health care paid by the payer under a policy or

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 *certificate of health insurance.]*

2 [(6) “Payer” means:]

3 [(a) An insurer offering a policy or certificate of health insurance or a health benefit plan as de-
4 fined in ORS 743B.005;]

5 [(b) A publicly funded health care program, including but not limited to Medicaid, Medicare and
6 the State Children’s Health Insurance Program;]

7 [(c) A third party administrator; and]

8 [(d) Any other public or private entity, other than an individual, that pays or reimburses the cost
9 for the provision of health care.]

10 [(7) “Provider” means an individual, organization or business entity that provides health care.]

11 [(8)(a) “Total health expenditures” means all health care expenditures on behalf of residents of this
12 state by public and private sources, including:]

13 [(A) All payments on providers’ claims for reimbursement of the cost of health care provided;]

14 [(B) All payments to providers other than payments described in subparagraph (A) of this para-
15 graph;]

16 [(C) All cost-sharing paid by residents of this state, including but not limited to copayments,
17 deductibles and coinsurance; and]

18 [(D) The net cost of private health insurance.]

19 [(b) “Total health expenditures” may include expenditures for care provided to out-of-state residents
20 by in-state providers to the extent practicable.]

21 **(2) “Premium costs” means the total amount of premiums paid by employers, employees,**
22 **individuals and groups in this state for a policy or certificate of health insurance or a health**
23 **benefit plan, as defined in ORS 743B.005, that reimburses the cost of health care.**

24 **SECTION 2.** ORS 442.386 is amended to read:

25 442.386. (1) [*The Legislative Assembly intends to establish a health care cost growth target, for all*
26 *providers and payers,*] **There is established the Premium Cost Growth Target program** to:

27 (a) Support accountability for [*the total cost of health care across all providers and payers, both*
28 *public and private*] **premium costs**;

29 (b) Build on the state’s existing efforts around health care payment reform and containment of
30 health care costs; and

31 (c) Ensure the long-term affordability and financial sustainability of the health care system in
32 this state.

33 (2) [*The Health Care Cost Growth Target program is established. The program*] **The program**
34 shall be administered by the Oregon Health Authority in collaboration with the Department of
35 Consumer and Business Services, subject to the oversight of the Oregon Health Policy Board. The
36 program shall establish a [*health care*] cost growth target for [*increases in total health expenditures*]
37 **premium costs** and shall review and modify the target on a periodic basis.

38 (3) The [*health care*] **premium** cost growth target must:

39 (a) Promote a predictable and sustainable rate of growth for [*total health expenditures*] **premium**
40 **costs** as measured by an economic indicator adopted by the board, such as the rate of increase in
41 this state’s economy or of the personal income of residents of this state;

42 [(b) Apply to all providers and payers in the health care system in this state;]

43 [(c)] **(b)** Use established economic indicators; and

44 [(d)] **(c)** Be measurable on a per capita basis[,] **and** statewide basis [*and health care entity*
45 *basis*].

1 (4) The program shall establish a methodology for calculating [*health care*] **premium** cost
2 growth:

3 (a) Statewide;

4 (b) For each [*provider and*] payer **of premiums**, taking into account the health status of the
5 [*patients of the provider or the*] beneficiary of the payer; and

6 (c) Per capita.

7 [(5) *The program shall establish requirements for providers and payers to report data and other*
8 *information necessary to calculate health care cost growth under subsection (4) of this section.*]

9 **(5) The department shall share with the authority information received by the depart-**
10 **ment under ORS 743.004 and 743.007 and information collected and analyzed by the depart-**
11 **ment in reviewing rates under ORS 743.019.**

12 (6) Annually, the program shall:

13 (a) Hold public hearings on the growth in [*total health expenditures*] **premium costs** in relation
14 to the [*health care*] **premium** cost growth in the previous calendar year;

15 (b) Publish a report on [*health care*] **premium** costs and spending trends that includes:

16 (A) Factors impacting **premium** costs [*and spending*]; and

17 (B) Recommendations for strategies to improve the efficiency of the health care system; and

18 (c) For [*providers and payers*] **insurers** for which [*health care*] **premium** cost growth in the
19 previous calendar year exceeded the [*health care*] **premium** cost growth target:

20 (A) Analyze the cause for exceeding the [*health care*] **premium** cost growth target; and

21 (B) Require the [*provider or payer*] **insurer** to develop and undertake a performance improve-
22 ment plan.

23 (7)(a) The authority shall adopt by rule criteria for waiving the requirement for [*a provider or*
24 *payer*] **an insurer** to undertake a performance improvement plan, if necessitated by unforeseen
25 market conditions or other equitable factors.

26 (b) The authority shall collaborate with [*a provider or payer*] **an insurer** that is required to
27 develop and undertake a performance improvement plan by:

28 (A) Providing a template for performance improvement plans, guidelines and a time frame for
29 submission of the plan;

30 (B) Providing technical assistance such as webinars, office hours, consultation with technical
31 assistance [*providers or*] staff, or other guidance; and

32 (C) Establishing a contact at the authority who can work with the [*provider or payer*] **insurer**
33 in developing the performance improvement plan.

34 (8) A performance improvement plan must:

35 (a) Identify key cost drivers and include concrete steps [*a provider or payer*] **an insurer** will
36 take to address the cost drivers;

37 (b) Identify an appropriate time frame by which [*a provider or payer*] **an insurer** will reduce the
38 cost drivers and be subject to an evaluation by the authority; and

39 (c) Have clear measurements of success.

40 (9) The authority shall adopt by rule criteria for imposing a financial penalty on any [*provider*
41 *or payer*] **insurer** that exceeds the **premium** cost growth target without reasonable cause in three
42 out of five calendar years or on any [*provider or payer*] **insurer** that does not participate in the
43 program. The criteria must be based on the degree to which the [*provider or payer*] **insurer** ex-
44 ceeded the target and other factors, including but not limited to:

45 (a) The size of the [*provider or payer organization*] **insurer**;

- 1 (b) The good faith efforts of the [*provider or payer*] **insurer** to address health care costs;
- 2 (c) The [*provider's or payer's*] **insurer's** cooperation with the authority or the department;
- 3 (d) Overlapping penalties that may be imposed for failing to meet the target, such as require-
- 4 ments relating to medical loss ratios; and
- 5 (e) [*A provider's or payer's*] **An insurer's** overall performance in reducing [*cost*] **premium costs**
- 6 across all markets served by the [*provider or payer*] **insurer**.

7 **SECTION 3.** ORS 415.500 is amended to read:

8 415.500. As used in this section and ORS 415.501 and 415.505:

9 (1) "Corporate affiliation" has the meaning prescribed by the Oregon Health Authority by rule,

10 including:

11 (a) Any relationship between two organizations that reflects, directly or indirectly, a partial or

12 complete controlling interest or partial or complete corporate control; and

13 (b) Transactions that merge tax identification numbers or corporate governance.

14 (2) "Essential services" means:

15 (a) Services that are funded on the prioritized list described in ORS 414.690; and

16 (b) Services that are essential to achieve health equity.

17 (3) "Health benefit plan" has the meaning given that term in ORS 743B.005.

18 (4)(a) "Health care entity" includes:

19 (A) An individual health professional licensed or certified in this state;

20 (B) A hospital, as defined in ORS 442.015, or hospital system, as defined by the authority by rule;

21 (C) A carrier, as defined in ORS 743B.005, that offers a health benefit plan in this state;

22 (D) A Medicare Advantage plan;

23 (E) A coordinated care organization or a prepaid managed care health services organization, as

24 both terms are defined in ORS 414.025; and

25 (F) Any other entity that has as a primary function the provision of health care items or ser-

26 vices or that is a parent organization of, or is an entity closely related to, an entity that has as a

27 primary function the provision of health care items or services.

28 (b) "Health care entity" does not include:

29 (A) Long term care facilities, as defined in ORS 442.015.

30 (B) Facilities licensed and operated under ORS 443.400 to 443.455.

31 (5) "Health equity" has the meaning prescribed by the Oregon Health Policy Board and adopted

32 by the authority by rule.

33 (6)(a) "Material change transaction" means:

34 (A) A transaction in which at least one party had average revenue of \$25 million or more in the

35 preceding three fiscal years and another party:

36 (i) Had an average revenue of at least \$10 million in the preceding three fiscal years; or

37 (ii) In the case of a new entity, is projected to have at least \$10 million in revenue in the first

38 full year of operation at normal levels of utilization or operation as prescribed by the authority by

39 rule.

40 (B) If a transaction involves a health care entity in this state and an out-of-state entity, a

41 transaction that otherwise qualifies as a material change transaction under this paragraph that may

42 result in increases in the price of health care or limit access to health care services in this state.

43 (b) "Material change transaction" does not include:

44 (A) A clinical affiliation of health care entities formed for the purpose of collaborating on clin-

45 ical trials or graduate medical education programs.

- 1 (B) A medical services contract or an extension of a medical services contract.
- 2 (C) An affiliation that[.]
- 3 [(i)] does not impact the corporate leadership, governance or control of an entity.[; and]
- 4 [(ii)] *Is necessary, as prescribed by the authority by rule, to adopt advanced value-based payment*
- 5 *methodologies to meet the health care cost growth targets under ORS 442.386.*]
- 6 (D) Contracts under which one health care entity, for and on behalf of a second health care
- 7 entity, provides patient care and services or provides administrative services relating to, supporting
- 8 or facilitating the provision of patient care and services, if the second health care entity:
- 9 (i) Maintains responsibility, oversight and control over the patient care and services; and
- 10 (ii) Bills and receives reimbursement for the patient care and services.
- 11 (E) Transactions in which a participant that is a health center as defined in 42 U.S.C. 254b,
- 12 while meeting all of the participant’s obligations, acquires, affiliates with, partners with or enters
- 13 into any agreement with another entity unless the transaction would result in the participant no
- 14 longer qualifying as a health center under 42 U.S.C. 254b.
- 15 (7)(a) “Medical services contract” means a contract to provide medical or mental health services
- 16 entered into by:
- 17 (A) A carrier and an independent practice association;
- 18 (B) A carrier, coordinated care organization, independent practice association or network of
- 19 providers and one or more providers, as defined in ORS 743B.001;
- 20 (C) An independent practice association and an individual health professional or an organization
- 21 of health care providers;
- 22 (D) Medical, dental, vision or mental health clinics; or
- 23 (E) A medical, dental, vision or mental health clinic and an individual health professional to
- 24 provide medical, dental, vision or mental health services.
- 25 (b) “Medical services contract” does not include a contract of employment or a contract creat-
- 26 ing a legal entity and ownership of the legal entity that is authorized under ORS chapter 58, 60 or
- 27 70 or under any other law authorizing the creation of a professional organization similar to those
- 28 authorized by ORS chapter 58, 60 or 70, as may be prescribed by the authority by rule.
- 29 (8) “Net patient revenue” means the total amount of revenue, after allowance for contractual
- 30 amounts, charity care and bad debt, received for patient care and services, including:
- 31 (a) Value-based payments;
- 32 (b) Incentive payments;
- 33 (c) Capitation payments or payments under any similar contractual arrangement for the pre-
- 34 payment or reimbursement of patient care and services; and
- 35 (d) Any payment received by a hospital to reimburse a hospital assessment under ORS 414.855.
- 36 (9) “Revenue” means:
- 37 (a) Net patient revenue; or
- 38 (b) The gross amount of premiums received by a health care entity that are derived from health
- 39 benefit plans.
- 40 (10) “Transaction” means:
- 41 (a) A merger of a health care entity with another entity;
- 42 (b) An acquisition of one or more health care entities by another entity;
- 43 (c) New contracts, new clinical affiliations and new contracting affiliations that will eliminate
- 44 or significantly reduce, as defined by the authority by rule, essential services;
- 45 (d) A corporate affiliation involving at least one health care entity; or

1 (e) Transactions to form a new partnership, joint venture, accountable care organization, parent
2 organization or management services organization, as prescribed by the authority by rule.

3 **SECTION 4.** ORS 415.501 is amended to read:

4 415.501. (1) The purpose of this section is to promote the public interest and to advance the
5 goals set forth in ORS 414.018 and the goals of the Oregon Integrated and Coordinated Health Care
6 Delivery System described in ORS 414.570.

7 (2) In accordance with subsection (1) of this section, the Oregon Health Authority shall adopt
8 by rule criteria approved by the Oregon Health Policy Board for the consideration of requests by
9 health care entities to engage in a material change transaction and procedures for the review of
10 material change transactions under this section.

11 (3)(a) A notice of a material change transaction involving the sale, merger or acquisition of a
12 domestic health insurer shall be submitted to the Department of Consumer and Business Services
13 as an addendum to filings required by ORS 732.517 to 732.546 or 732.576. The department shall
14 provide to the authority the notice submitted under this subsection to enable the authority to con-
15 duct a review in accordance with subsections (5) and (7) of this section. The authority shall notify
16 the department of the outcome of the authority's review.

17 (b) The department shall make the final determination in material change transactions involving
18 the sale, merger or acquisition of a domestic health insurer and shall coordinate with the authority
19 to incorporate the authority's review into the department's final determination.

20 (4) An entity shall submit to the authority a notice of a material change transaction, other than
21 a transaction described in subsection (3) of this section, in the form and manner prescribed by the
22 authority, no less than 180 days before the date of the transaction and shall pay a fee prescribed in
23 ORS 415.512.

24 (5) No later than 30 days after receiving a notice described in subsections (3) and (4) of this
25 section, the authority shall conduct a preliminary review to determine if the transaction has the
26 potential to have a negative impact on access to affordable health care in this state and meets the
27 criteria in subsection (9) of this section.

28 (6) Following a preliminary review, the authority or the department shall approve a transaction
29 or approve a transaction with conditions designed to further the goals described in subsection (1)
30 of this section based on criteria prescribed by the authority by rule, including but not limited to:

31 (a) If the transaction is in the interest of consumers and is urgently necessary to maintain the
32 solvency of an entity involved in the transaction; or

33 (b) If the authority determines that the transaction does not have the potential to have a nega-
34 tive impact on access to affordable health care in this state or the transaction is likely to meet the
35 criteria in subsection (9) of this section.

36 (7)(a) Except as provided in paragraph (b) of this subsection, if a transaction does not meet the
37 criteria in subsection (6) of this section, the authority shall conduct a comprehensive review and
38 may appoint a review board of stakeholders to conduct a comprehensive review and make recom-
39 mendations as provided in subsections (11) to (18) of this section. The authority shall complete the
40 comprehensive review no later than 180 days after receipt of the notice unless the parties to the
41 transaction agree to an extension of time.

42 (b) The authority or the department may intervene in a transaction described in ORS 415.500
43 [(6)(a)(C)] **(6)(a)(B)** in which the final authority rests with another state and, if the transaction is
44 approved by the other state, may place conditions on health care entities operating in this state with
45 respect to the insurance or health care industry market in this state, prices charged to patients

1 residing in this state and the services available in health care facilities in this state, to serve the
2 public good.

3 (8) The authority shall prescribe by rule:

4 (a) Criteria to exempt an entity from the requirements of subsection (4) of this section if there
5 is an emergency situation that threatens immediate care services and the transaction is urgently
6 needed to protect the interest of consumers;

7 (b) Provision for the authority's failure to complete a review under subsection (5) of this section
8 within 30 days; and

9 (c) Criteria for when to conduct a comprehensive review and appoint a review board under
10 subsection (7) of this section that must include, but is not limited to:

11 (A) The potential loss or change in access to essential services;

12 (B) The potential to impact a large number of residents in this state; or

13 (C) A significant change in the market share of an entity involved in the transaction.

14 (9) A health care entity may engage in a material change transaction if, following a compre-
15 hensive review conducted by the authority and recommendations by a review board appointed under
16 subsection (7) of this section, the authority determines that the transaction meets the criteria
17 adopted by the [department] **authority** by rule under subsection (2) of this section and:

18 (a)(A) The parties to the transaction demonstrate that the transaction will benefit the public
19 good and communities by:

20 *[(i) Reducing the growth in patient costs in accordance with the health care cost growth targets*
21 *established under ORS 442.386 or maintain a rate of cost growth that exceeds the target that the entity*
22 *demonstrates is the best interest of the public;]*

23 *[(ii)]* (i) Increasing access to services in medically underserved areas; or

24 *[(iii)]* (ii) Rectifying historical and contemporary factors contributing to a lack of health equities
25 or access to services; or

26 (B) The transaction will improve health outcomes for residents of this state; and

27 (b) There is no substantial likelihood of anticompetitive effects from the transaction that out-
28 weigh the benefits of the transaction in increasing or maintaining services to underserved popu-
29 lations.

30 (10) The authority may suspend a proposed material change transaction if necessary to conduct
31 an examination and complete an analysis of whether the transaction is consistent with subsection
32 (9) of this section and the criteria adopted by rule under subsection (2) of this section.

33 (11)(a) A review board convened by the authority under subsection (7) of this section must con-
34 sist of members of the affected community, consumer advocates and health care experts. No more
35 than one-third of the members of the review board may be representatives of institutional health
36 care providers. The authority may not appoint to a review board an individual who is employed by
37 an entity that is a party to the transaction that is under review or is employed by a competitor that
38 is of a similar size to an entity that is a party to the transaction.

39 (b) A member of a review board shall file a notice of conflict of interest and the notice shall
40 be made public.

41 (12) The authority may request additional information from an entity that is a party to the ma-
42 terial change transaction, and the entity shall promptly reply using the form of communication re-
43 quested by the authority and verified by an officer of the entity if required by the authority.

44 (13)(a) An entity may not refuse to provide documents or other information requested under
45 subsection (4) or (12) of this section on the grounds that the information is confidential.

1 (b) Material that is privileged or confidential may not be publicly disclosed if:

2 (A) The authority determines that disclosure of the material would cause harm to the public;

3 (B) The material may not be disclosed under ORS 192.311 to 192.478; or

4 (C) The material is not subject to disclosure under ORS 705.137.

5 (c) The authority shall maintain the confidentiality of all confidential information and documents
6 that are not publicly available that are obtained in relation to a material change transaction and
7 may not disclose the information or documents to any person, including a member of the review
8 board, without the consent of the person who provided the information or document. Information
9 and documents described in this paragraph are exempt from disclosure under ORS 192.311 to 192.478.

10 (14) The authority or the Department of Justice may retain actuaries, accountants or other
11 professionals independent of the authority who are qualified and have expertise in the type of ma-
12 terial change transaction under review as necessary to assist the authority in conducting the anal-
13 ysis of a proposed material change transaction. The authority or the Department of Justice shall
14 designate the party or parties to the material change transaction that shall bear the reasonable and
15 actual cost of retaining the professionals.

16 (15) A review board may hold up to two public hearings to seek public input and otherwise en-
17 gage the public before making a determination on the proposed transaction. A public hearing must
18 be held in the service area or areas of the health care entities that are parties to the material
19 change transaction. At least 10 days prior to the public hearing, the authority shall post to the
20 authority's website information about the public hearing and materials related to the material
21 change transaction, including:

22 (a) A summary of the proposed transaction;

23 (b) An explanation of the groups or individuals likely to be impacted by the transaction;

24 (c) Information about services currently provided by the health care entity, commitments by the
25 health care entity to continue such services and any services that will be reduced or eliminated;

26 (d) Details about the hearings and how to submit comments, in a format that is easy to find and
27 easy to read; and

28 (e) Information about potential or perceived conflicts of interest among executives and members
29 of the board of directors of health care entities that are parties to the transaction.

30 (16) The authority shall post the information described in subsection (15)(a) to (d) of this section
31 to the authority's website in the languages spoken in the area affected by the material change
32 transaction and in a culturally sensitive manner.

33 (17) The authority shall provide the information described in subsection (15)(a) to (d) of this
34 section to:

35 (a) At least one newspaper of general circulation in the area affected by the material change
36 transaction;

37 (b) Health facilities in the area affected by the material change transaction for posting by the
38 health facilities; and

39 (c) Local officials in the area affected by the material change transaction.

40 (18) A review board shall make recommendations to the authority to approve the material
41 change transaction, disapprove the material change transaction or approve the material change
42 transaction subject to conditions, based on subsection (9) of this section and the criteria adopted
43 by rule under subsection (2) of this section. The authority shall issue a proposed order and allow
44 the parties and the public a reasonable opportunity to make written exceptions to the proposed or-
45 der. The authority shall consider the parties' and the public's written exceptions and issue a final

1 order setting forth the authority's findings and rationale for adopting or modifying the recommen-
2 dations of the review board. If the authority modifies the recommendations of the review board, the
3 authority shall explain the modifications in the final order and the reasons for the modifications. A
4 party to the material change transaction may contest the final order as provided in ORS chapter
5 183.

6 (19) A health care entity that is a party to an approved material change transaction shall notify
7 the authority upon the completion of the transaction in the form and manner prescribed by the au-
8 thority. One year, two years and five years after the material change transaction is completed, the
9 authority shall analyze:

10 (a) The health care entities' compliance with conditions placed on the transaction, if any; **and**

11 (b) The cost trends and cost growth trends of the parties to the transaction.[: *and*]

12 [*(c) The impact of the transaction on the health care cost growth target established under ORS*
13 *442.386.*]

14 (20) The authority shall publish the authority's analyses and conclusions under subsection (19)
15 of this section [*and shall incorporate the authority's analyses and conclusions under subsection (19)*
16 *of this section in the report described in ORS 442.386 (6)*].

17 (21) This section does not impair, modify, limit or supersede the applicability of ORS 65.800 to
18 65.815, 646.605 to 646.652 or 646.705 to 646.805.

19 (22) Whenever it appears to the Director of the Oregon Health Authority that any person has
20 committed or is about to commit a violation of this section or any rule or order issued by the au-
21 thority under this section, the director may apply to the Circuit Court for Marion County for an
22 order enjoining the person, and any director, officer, employee or agent of the person, from the vi-
23 olation, and for such other equitable relief as the nature of the case and the interest of the public
24 may require.

25 (23) The remedies provided under this section are in addition to any other remedy, civil or
26 criminal, that may be available under any other provision of law.

27 (24) The authority may adopt rules necessary to carry out the provisions of this section.

28 **SECTION 5.** ORS 442.993 is amended to read:

29 442.993. (1) The Oregon Health Authority shall adopt a schedule of civil penalties not to exceed
30 \$500 per day of violation, determined by the severity of the violation, for:

31 (a) Any reporting entity that fails to report as required by ORS 442.373 or rules adopted by the
32 authority.

33 (b) Any [*provider or payer*] **insurer** that fails to report [*cost growth*] **premium cost** data or to
34 develop and implement a performance improvement plan if required by ORS 442.386 or rules adopted
35 by the authority.

36 (2) Civil penalties under this section shall be imposed as provided in ORS 183.745.

37 (3) Civil penalties imposed under this section may be remitted or mitigated upon such terms and
38 conditions as the authority considers proper and consistent with the public health and safety.

39 (4) Civil penalties incurred under any law of this state are not allowable as costs for the purpose
40 of rate determination or for reimbursement by a third-party payer.

41 (5) Moneys collected from providers and payers described in subsection (1)(b) of this section
42 shall be deposited in the Oregon Health Authority Fund established by ORS 413.101 and used by the
43 authority to support programs that expand access to health care and that support populations ad-
44 versely affected by high health care costs.

45 **SECTION 6.** Section 7, chapter 51, Oregon Laws 2021, is amended to read:

1 **Sec. 7.** A financial penalty described in ORS 442.386 (9), as amended by section 2, [*of this 2021*
2 *Act*] **chapter 51, Oregon Laws 2021**, may be imposed no earlier than January 1, 2026, for perform-
3 ance by [*a provider or payer*] **an insurer** in meeting cost growth targets during calendar years 2021
4 to 2025.

5
