

CHAPTER 26

AN ACT

HB 4017

Relating to health care; creating new provisions; amending ORS 678.038 and sections 3 and 5, chapter 575, Oregon Laws 2015; and declaring an emergency.

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

SECTION 1. (1) As used in this section:

(a) "Basic Health Program" means a program certified by the United States Secretary of Health and Human Services under 42 U.S.C. 18051.

(b) "Blueprint" means the written document described in 42 C.F.R. 600.110.

(c) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(d) "Health insurance exchange" has the meaning given that term in ORS 741.300.

(e) "Standard health plan" means a health plan available through the Basic Health Program.

(2) The Department of Consumer and Business Services shall obtain, as necessary, updates of the data produced in the feasibility study commissioned under section 1, chapter 96, Oregon Laws 2014, to use in developing the report described in subsection (3) of this section.

(3) Not later than December 31, 2016, the department, in collaboration with the Oregon Health Authority and in consultation with the stakeholder advisory group created in subsection (6) of this section, shall create and present to the interim committees of the Legislative Assembly related to health a report containing a blueprint for a Basic Health Program.

(4) In developing the blueprint, the department, authority and stakeholder advisory group shall consider and address the following recommendations contained in the report produced in accordance with section 1, chapter 256, Oregon Laws 2015:

(a) The Basic Health Program should serve, at a minimum, residents of this state who are:

(A) Under 65 years of age;

(B) Not eligible to enroll in employer-sponsored health insurance that is affordable as determined under 26 U.S.C. 36B(c)(2)(C); and

(C)(i) United States citizens with incomes at or above 138 percent but no greater than 200 percent of the federal poverty guidelines and who do not qualify for the state medical assistance program or TRICARE; or

(ii) Lawfully present noncitizens with incomes below 200 percent of the federal poverty guidelines, including those who would qualify for the state medical assistance program but for their immigration status or the duration of their residency in the United States.

(b) Basic Health Program participants should be able to use the health insurance exchange Internet portal to enroll in a standard health plan.

(c) Basic Health Program participants should have the choice of enrolling in a standard health plan offered by a coordinated care organization or a commercial insurer.

(d) The standard health plan should cover the same health benefits that are covered in the state medical assistance program and should conform to the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (1).

(e) Basic Health Plan participants should not be subject to deductibles, coinsurance, copayments or other cost-sharing requirements.

(f) Basic Health Program participants whose incomes are below 138 percent of the federal poverty guidelines should not be required to pay premiums.

(g) Premiums for Basic Health Program participants whose incomes are at or above 138 percent of the federal poverty guidelines should be based on a sliding scale that ensures that the premiums are not greater than the premiums participants would pay for qualified health plans purchased on the health insurance exchange minus the premium tax credit described in 26 U.S.C. 36B.

(h) Basic Health Program participants should be eligible to remain continuously enrolled in a standard health plan for a period of 12 consecutive months as long as they reside in this state.

(i) Health care providers should be reimbursed for the services provided to Basic Health Program participants at a rate equal to the average of the rate paid by Medicare and the rate paid by commercial insurers for the services.

(j) The cost of the Basic Health Program should be maintained at a fixed rate of growth annually.

(5) The report presented to the interim committees of the Legislative Assembly must include the administrative framework for grievance procedures, for premium billing and for providing customer service to Basic Health Program participants.

(6) The department and the authority shall convene a stakeholder advisory group consisting, at a minimum, of:

(a) Advocates for low-income individuals and families;

(b) Advocates for consumers of health care;

(c) Representatives of health care provider groups;

(d) Representatives of coordinated care organizations; and

(e) Representatives of the health insurance industry.

SECTION 2. (1) Subject to subsection (2) of this section, the Department of Consumer and Business Services shall have sole authority to apply for a waiver for state innovation under 42 U.S.C. 18052. In developing an application for a waiver, the department shall convene an advisory group to advise and assist the department in identifying federal provisions subject to waiver that are expected to improve the delivery of quality health care to residents of this state including, but not limited to, alternative approaches for achieving the objectives of the Basic Health Program as described in section 1 (4) of this 2016 Act.

(2) The department may not submit an application for a waiver to the United States Secretary of Health and Human Services or Secretary of the Treasury until the department has presented the proposed application for a waiver to the committees of the Legislative Assembly related to health and to the Legislative Assembly as specified in subsection (3) of this section.

(3) Not later than March 1, 2017, the department shall report to the Legislative Assembly, in the manner provided in ORS 192.245, its recommendations for submitting an application for a waiver under 42 U.S.C. 18052.

SECTION 3. Notwithstanding any other law limiting expenditures, the amount of \$415,000 is established for the biennium beginning July 1, 2015, as the maximum limit for payment of expenses for carrying out the provisions of sections 1 and 2 of this 2016 Act, from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Department of Consumer and Business Services.

SECTION 4. Section 5 of this 2016 Act is added to and made a part of ORS chapter 414.

SECTION 5. (1) As used in this section:

(a) "Approved clinical trial" has the meaning given that term in ORS 743A.192.

(b) "Routine health care":

(A) Means the types and extent of health care and services that the Oregon Health Authority requires to be provided in medical assistance in accordance with ORS 414.065.

(B) Does not include:

(i) The drug, device or service being tested in an approved clinical trial, unless a coordinated care organization would provide or pay for the drug, device or service if provided to a member who is not enrolled in an approved clinical trial;

(ii) Items or services required solely for the provision of the drug, device or service being tested in an approved clinical trial;

(iii) Items or services required solely for the clinically appropriate monitoring of the drug,

device or service being tested in an approved clinical trial;

(iv) Items or services that are provided solely to satisfy data collection and analysis needs associated with an approved clinical trial and that are not used in the direct clinical management of the member; or

(v) Items or services customarily provided by a clinical trial sponsor free of charge to any participant in an approved clinical trial.

(2) A coordinated care organization may not discriminate against a member on the basis of the member's participation in an approved clinical trial by:

(a) Denying the provision of or payment for routine health care; or

(b) Excluding, limiting or imposing additional conditions on the provision of or payment for routine health care furnished in connection with the member's participation in an approved clinical trial.

(3) A coordinated care organization that provides routine health care to a member enrolled in an approved clinical trial is not, based on the provision of that care, liable for any adverse effects of the approved clinical trial.

SECTION 6. ORS 678.038 is amended to read:

678.038. A registered nurse who is employed by a public or private school, or by an education service district or a local public health authority as defined in ORS 431.003 to provide nursing services at a public or private school, may accept an order from a physician licensed to practice medicine or osteopathy in another state or territory of the United States if the order is related to the care or treatment of a student who has been enrolled at the school for not more than 90 days.

SECTION 7. Section 3, chapter 575, Oregon Laws 2015, is amended to read:

Sec. 3. No later than February 1[, 2016,] of each year, the Oregon Health Authority and the Department of Consumer and Business Services shall report to the Legislative Assembly, in the manner provided in ORS 192.245:

(1) The percentage of the medical expenses of carriers, coordinated care organizations, the Public Employees' Benefit Board and the Oregon Educators Benefit Board that is allocated to primary care; and

(2) How carriers, coordinated care organizations, the Public Employees' Benefit Board and the Oregon Educators Benefit Board pay for primary care.

SECTION 8. Section 5, chapter 575, Oregon Laws 2015, is amended to read:

Sec. 5. (1) Sections 1, [to] 2 and 4, [of this 2015 Act] chapter 575, Oregon Laws 2015, are repealed on December 31, 2018.

(2) Section 3, chapter 575, Oregon Laws 2015, is repealed on January 2, 2020.

SECTION 9. This 2016 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2016 Act takes effect on its passage.

Approved by the Governor March 8, 2016
Filed in the office of Secretary of State March 9, 2016
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