Senate Bill 27

Sponsored by Senators JOHNSON, BURDICK, COURTNEY, DECKERT, GORDLY, KRUSE, METSGER, MORRISETTE, MORSE, PROZANSKI, SCHRADER, WINTERS, Representatives BONAMICI, BOONE, BUCKLEY, CANNON, CLEM, COWAN, GREENLICK, JENSON, KOMP, KOTEK, ROSENBAUM, TOMEI (at the request of The Archimedes Movement)

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.**

Creates Oregon Health Fund to pool state and federal expenditures for health care in Oregon and to finance treatment of defined set of essential health conditions for all Oregonians. Continuously appropriates moneys in fund to Oregon Health Plan Board for purpose of providing health services to all Oregon residents.

Creates Oregon Health Fund Board to manage Oregon Health Fund. Requires board to establish certain subcommittees for specified purposes.

Restructures Health Services Commission and imposes new criteria for developing prioritized list of health conditions.

Requires Governor, within 90 days of passage of Act, to request congressional approval to redirect federal moneys into Oregon Health Fund, contingent upon development of implementation plan by Oregon Health Fund Board. Requires Governor, upon approval of request, to submit implementation plan to next following regular session of Legislative Assembly for consideration.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health; creating new provisions; amending ORS 414.707, 414.715, 414.720, 414.735 and 414.745; repealing ORS 414.709; appropriating money; and declaring an emergency.

Whereas the objective of our health care system is health, not just the financing and delivery of health care services; and

Whereas health is more than just the absence of physical and mental disease; it is the product of a number of factors, only one of which is access to our medical system; and

Whereas we cannot achieve the objective of health unless all individuals have timely access to the effective treatment of a defined set of essential and effective health conditions; and

Whereas we cannot achieve the objective of health unless we invest not only in health care, but also in education, economic opportunity, housing, sustainable environmental stewardship and other areas which are important contributing factors to health; and

Whereas the escalating cost of health care is compromising our ability to invest in those other areas that contribute to the health of the population; and

Whereas we cannot achieve our objective of health unless we can control costs in the health care system; and

Whereas we cannot control costs unless we:

(1) Develop effective strategies to empower individuals through education as well as financial incentives and disincentives to assume more personal responsibility for their own health status through the choices they make;

(2) Reevaluate the structure of our 50-year federal financing and eligibility system in light of the realities and circumstances of the 21st century and of what we want the system to achieve from the standpoint of the health of our population; and

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.

(3) Rethink how we define a "benefit" and restructure the misaligned financial incentives and inefficient system through which health care is currently delivered; and

Whereas public resources are finite, and therefore the public resources available for health care are also finite; and

Whereas finite resources require that explicit priorities be set through an open process with public input to determine what will and will not be financed with public resources; and

Whereas those with more disposable private income will always be able to purchase more health care than those who depend solely on public resources; and

Whereas the current health care system is unsustainable in large part because of outdated federal policies that reflect the realities of the last century instead of the realities of today and which are based on assumptions that are no longer valid; and

Whereas the ability of states to maintain the public's health is increasingly constrained by those federal policies, which were built around "categories" rather than a commitment to ensure all citizens have timely access to the effective treatment of essential health conditions; and

Whereas public subsidies of employer-sponsored health coverage under the Tax Reform Act of 1954, Medicaid and Medicare, which were established through three specific acts of Congress in the last century, were enacted separately at different times for different reasons and reflect no sense of common purpose; and

Whereas the economic and demographic environment in which those federal programs were created has changed dramatically over the past 50 years, while the programs themselves continue to reflect a set of circumstances that existed in the mid-20th century; and

Whereas any reform effort that fails to address the contradictions and inequities embodied in the federal programs and fails to bring them into alignment with the realities of the 21st century will also fail to achieve meaningful reform, perpetuating the status quo and the contradictions, inequities and consequences existing in the current system; and

Whereas any strategies for financing, mandating or developing new programs to expand access must address what will be covered with public resources and how those services will be delivered. Otherwise, those strategies will do little to stem escalating medical costs, make health care more affordable or create a sustainable system; and

Whereas Oregon must take immediate action to request that those federal programs be amended so that the public dollars currently being spent on health care within the state can be allocated to create a sustainable system which will optimize the health of Oregonians; now, therefore,

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

SECTION 1. Sections 1 to 14 of this 2007 Act and ORS 414.707, 414.715, 414.720, 414.735 and 414.745, as amended by sections 15 to 19 of this 2007 Act, shall be known as the Oregon Better Health Act.

SECTION 2. It is the intent of the Legislative Assembly in enacting the Oregon Better Health Act to:

(1) Recognize that clinging to the system of employer-sponsored coverage as it is currently structured is not an option and to:

(a) Recognize that the current structure makes much less sense now than it did when the economic forces and incentives that created it were put in place over 50 years ago;

(b) Rethink the structure of the current system of employer-sponsored coverage in light of the realities of a highly competitive global economy, the increased mobility of the workforce and the changing structure of the workplace; and

(c) Develop a way to finance the treatment of a defined set of essential health conditions that are not tied to employment, relieving employers and employees of this cost while still leaving employers the option of offering secondary coverage designed to best service the specific needs of their particular workforce;

(2) Recognize that clinging to the current structure of Medicaid is not an option and to:

(a) Eliminate the need for a special program for the poor by ensuring that all Oregonians, including the most vulnerable members of our society, have access to treatment for at least the same defined set of essential health conditions;

(b) Ensure that the medical and health needs of the blind and those with other disabilities and special needs are met in a timely and cost-effective manner with treatments that produce quality outcomes; and

(c) Eliminate the complexity and administrative cost of assigning equally impoverished and vulnerable groups of Oregonians into dozens of different eligibility categories to determine how their care will be financed; and

(3) Reconsider the current structure of the Medicare program, but not to dismantle it, and to:

(a) Recognize that clinging to the current structure of Medicare is not an option;

(b) Rethink the current structure of Medicare in light of the huge demographic trends and advances in medical technology that have taken place since it was created in 1965;

(c) More rationally and honestly identify the medical and health needs of an aging population and to ensure that those needs are met in a timely and cost-effective manner with treatments that produce quality outcomes; and

(d) Balance, in an equitable and sustainable manner, the medical and health needs of the elderly with those of the nonelderly and ensure that this balance is reflected in the allocation of public resources for health care.

SECTION 3. The Oregon Better Health Act is based on the following principles:

(1) Equity. All individuals must be eligible for and have timely access to treatment for at least the same set of essential and effective health conditions.

(2) Financing. Financing of the health care system must be equitable, broadly based and affordable.

(3) Population benefit. The public must set priorities to optimize the health of Oregonians.

(4) Responsibility. Responsibility for optimizing health must be shared by individuals, employers, health systems and communities.

(5) Education. Education is a powerful tool for health promotion. The health care system must promote and engage in education activities for individuals, health systems and communities.

(6) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.

(7) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.

(8) Explicit decision-making. Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.

(9) Transparency. The evidence used to support decisions must be clear, understandable

and observable to the public.

(10) Economic sustainability. Health service expenditures must be managed to ensure sustainability over the long term, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.

(11) Aligned financial incentives. Financial incentives must be aligned to support and invest in activities that will achieve the goals of this 2007 Act.

(12) Wellness. Health and wellness promotion efforts must be emphasized and strengthened.

(13) Community-based. The delivery of care and distribution of resources must be organized to take place at the community level, unless outcomes or cost can be improved at regional or statewide levels.

(14) Coordination. Collaboration, coordination and integration of care and resources must be emphasized throughout the health system.

SECTION 4. (1) The Oregon Health Fund is established separate and distinct from the General Fund. Interest earned from the investment of moneys in the Oregon Health Fund shall be credited to the fund. The Oregon Health Fund shall include, but is not limited to:

(a) Medicare funds under Title XVIII of the Social Security Act;

(b) Medicaid funds under Title XIX of the Social Security Act;

(c) General Fund moneys that would otherwise be spent in the Medicaid program; and

(d) The value of state tax expenditures for employer-sponsored health insurance coverage.

(2) All moneys in the Oregon Health Fund are continuously appropriated to the Oregon Health Fund Board for the purpose of providing health services to all Oregon residents.

SECTION 5. (1) There is established the Oregon Health Fund Board. The board shall consist of up to nine members appointed by the Governor, subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution. The members of the board must include individuals with actuarial and financial management experience, individuals who are providers of health care and individuals who are consumers of health care.

(2) Each board member shall serve for a term of four years. However, a board member shall serve until a successor has been appointed and qualified. A member is eligible for reappointment.

(3) If there is a vacancy for any cause, the Governor shall make an appointment to become effective immediately for the balance of the unexpired term.

(4) Members of the board are in the exempt service under ORS chapter 240, and the Governor shall fix their salaries in accordance with ORS 240.245.

(5) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(6) A majority of the members of the board constitutes a quorum for the transaction of business.

(7) Official action by the board requires the approval of a majority of the members of the board.

SECTION 6. Notwithstanding the term of office specified by section 5 of this 2007 Act, of the members first appointed to the Oregon Health Fund Board:

(1) Three shall serve for a term ending January 1, 2010.

(2) Three shall serve for a term ending January 1, 2011.

(3) The remaining appointees shall serve for a term ending January 1, 2012.

SECTION 7. (1) The Oregon Health Fund Board shall appoint an executive director to serve at the pleasure of the board.

(2) The designation of the executive director must be by written order filed with the Secretary of State.

(3) Subject to any applicable provisions of ORS chapter 240, the executive director is authorized to hire, supervise and terminate the employees of the board, prescribe their duties and fix their compensation.

SECTION 8. The Oregon Health Fund Board shall:

(1) Establish a subcommittee to develop options, using the criteria in section 9 of this 2007 Act, for a collection mechanism to capture the value of the public subsidy of employer-sponsored coverage through state and federal tax expenditures, and redirect it to the Oregon Health Fund. The subcommittee must include both small and large business interests, including those offering coverage as well as those not offering coverage, employees of those businesses and self-employed individuals;

(2) Establish a subcommittee to make recommendations on the most efficient and effective delivery system models producing quality outcomes for consideration in the actuarial process described in ORS 414.720 (6). Membership must include, but not be limited to, primary care physicians, specialists, nurse practitioners, mental health providers, dentists and providers from community health centers and rural health clinics;

(3) Establish a subcommittee to develop a plan to finance and implement the health information technology services and infrastructure described in section 12 of this 2007 Act;

(4) Establish a subcommittee to develop a proposal to empower individuals through education as well as financial incentives and disincentives to assume more personal responsibility for their own health status through the choices they make. The subcommittee shall consider the recommendations of the Health Services Commission concerning investments in nonclinical services and programs that have a bearing on the health of the population as required in ORS 414.720 (4)(e). The Oregon Health Fund Board shall submit the proposal to an independent actuary to determine the cost of implementation and then to the Governor and Legislative Assembly for consideration;

(5) Establish a subcommittee to make recommendations concerning how to address the issue of medical liability including, but not limited to, a consideration of the implementation of a Medical Review Panel and a Patient's Compensation Fund, and providing liability protection for those providers who adhere to established best-practice standards and guidelines;

(6) Manage the Oregon Health Fund;

(7) Oversee the actuarial process described in ORS 414.720 (6) to define the set of essential health conditions;

(8) Conduct public hearings to determine the adequacy of the defined set of essential health conditions in meeting the goals of section 2 of this 2007 Act and report the findings to the Governor and the Legislative Assembly; and

(9) Contract with privately and publicly sponsored health care organizations in accordance with section 10 of this 2007 Act.

SECTION 9. The mechanism to collect the public subsidy of employer-sponsored coverage

must:

(1) Not create a incentive for employers to discontinue coverage through the workplace;

(2) Address the inequities between employers that do and do not offer coverage;

(3) Recognize that small employers may have less margin with which to contribute to the cost of their employees′ health care; and

(4) Take into account the global economy, the mobility of the workforce and the changing structure of the workplace.

SECTION 10. (1) The Oregon Health Fund Board shall enter into contracts with privately and publicly sponsored health care organizations for the treatment of the defined set of essential health conditions developed in ORS 414.720. The health care organizations shall include, but are not limited to, private health plans and insurers, health care service contractors, independent practice associations, managed care health services organizations, community clinics, community health centers, rural health clinics and federally qualified health centers.

(2) The contracts must include standards for quality, performance and transparency, including transparency in costs, charges and outcomes.

(3) All Oregonians must be covered for the treatment of the same defined set of essential health conditions and the capitation rate must be the same for all contracting health care organizations.

(4) The health care organizations must be community-rated and must compete with each other to enroll Oregonians on the basis of outcomes, service and the secondary coverage described in subsection (9) of this section.

(5) There must be no underwriting. Instead, each contract shall contain a risk-adjusted formula.

(6) The board shall establish a minimum medical loss ratio for the health care organizations.

(7) The board may create a high-risk pool spread over the entire population to help subsidize those health care organizations that assume more risk.

(8) Individuals may choose their own health care organization or employers may continue to serve as health insurance distributors for their employees.

(9) Health care organizations may offer secondary coverage for services not included in the treatment of the defined set of essential health conditions, but to do so they must also offer coverage for the treatment of the defined set of essential set of health conditions.

SECTION 11. (1) Individuals or employers may supplement coverage of the defined set of essential health conditions provided by the Oregon Health Fund by purchasing secondary coverage from health care organizations.

(2) Secondary coverage must be separate and distinct from coverage for the treatment of the defined set of essential health conditions.

(3) The cost of secondary coverage purchased under this section may not be deducted from state income taxes.

SECTION 12. The Oregon Health Fund Board shall:

(1) Encourage the use of information technology that is cost-neutral or has a positive return on investment, to deliver efficient, safe, quality care; and

(2) Implement a voluntary program to provide every Oregonian with a personal health record. The personal electronic health record must be owned by the individual who will con-

trol the use of and access to the information stored in it. The personal electronic health record must be portable and not tied to a health care organization, employer or governmental entity.

SECTION 13. The Governor shall:

(1) Within 90 days of the development of an implementation plan by the Oregon Health Fund Board under section 14 of this 2007 Act, request from Congress the authority for Oregon to access the Medicare funds, Medicaid funds and the value of federal tax expenditures being spent on health care in Oregon, in order to create a sustainable system that optimizes the health of all Oregonians. The request shall include a description of the contradictions and inequities of current federal policies, the consequences of those policies for the State of Oregon, and the principles set forth in section 3 of this 2007 Act that provide the context for reallocating the public resources currently being spent on health care.

(2) Direct the Oregon Health Fund Board and the Health Services Commission to begin the process described in ORS 414.720 of establishing priorities among health conditions and determining the cost of treating a defined set of essential health conditions for which all Oregonians are eligible. In this process, the board and the commission shall assume that Oregon will receive the necessary congressional authority to reallocate federal moneys described in subsection (1) of this section that are currently being spent in this state on health care.

(3) Direct the Oregon Health Fund Board to establish the five subcommittees described in section 8 of this 2007 Act to begin to carry out their charges.

SECTION 14. (1) Based upon the recommendations of the five subcommittees described in section 8 of this 2007 Act, the Oregon Health Fund Board shall develop a plan to implement the provisions of the Oregon Better Health Act. This plan must be completed prior to the next regular Legislative Assembly.

(2) In developing the plan described in subsection (1) of this section, the board shall conduct public hearings and solicit testimony and information from advocates representing seniors, persons with disabilities, consumers of mental health services, low-income Oregonians, employers, employees, insurers and health plans and providers of health care including, but not limited to, physicians, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

(3) The plan shall detail:

(a) The administrative and governing structures of the new system on both the state and community levels;

(b) The structure of the delivery system, including standards for quality transparency and accountability as well as performance measures; and

(c) The actuarial process used to determine the cost of treating the defined set of essential health conditions to produce quality outcomes and to align the financial incentives in the system with the purposes of the Oregon Better Health Act expressed in section 2 of this 2007 Act.

(4) The board shall develop a transition plan that details the changes, resources and time frames necessary to make an orderly transition from the current system to the new system.

(5) The board shall conduct public hearings on the proposed plan.

(6) The board shall finalize the plan based upon information provided in the public hearings in subsection (5) of this section and submit the plan to the Governor for approval.

The Governor shall present the plan as a legislative proposal to the next regular Legislative Assembly following the Governor's approval of the plan.

SECTION 15. ORS 414.707 is amended to read:

414.707. (1) Subject to funds available:

(a) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o), and persons under 19 years of age and pregnant women who are eligible to receive health services under ORS 414.706, are eligible to receive all the health services approved and funded by the Legislative Assembly.

(b) Persons described in ORS 414.708 are eligible to receive the health services described in ORS 414.705 (1)(c), (f) and (g).

(c) Persons 19 years of age and older who are eligible to receive health services under ORS 414.706 are eligible to receive the health services described in ORS 414.705 (1)(b) to (m).

(2) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o), and persons under 19 years of age and pregnant women who are eligible to receive health services under ORS 414.706, must be provided, at a minimum, the health services described in ORS 414.705 (1)(a) to (g).

(3) Persons 19 years of age and older who are eligible to receive health services under ORS 414.706 must be provided, at a minimum, health services described in ORS 414.705 (1)(b) to (h).

(4) Persons described in ORS 414.708 must be provided, at a minimum, the health services described in ORS 414.705 (1)(c).

[*(5) The Department of Human Services shall:*]

[*(a) Develop at least three benefit packages of provider services to be offered under ORS 414.705 (1)(j); and*]

[*(b) Define by rule the services to be offered under ORS 414.705 (1)(k).*]

[*(6) Notwithstanding ORS 414.735, the Legislative Assembly shall adjust health services funded under ORS 414.705 (1) by increasing or reducing benefit packages or health services and, subject to ORS 414.709, by increasing or reducing the population of eligible persons*].

SECTION 16. ORS 414.715 is amended to read:

414.715. (1) The Health Services Commission is established, consisting of 11 members appointed by the Governor and confirmed by the Senate. [*Five members shall be physicians licensed to practice medicine in this state who have clinical expertise in the general areas of obstetrics, perinatal, pediatrics, adult medicine, mental health and chemical dependency, disabilities, geriatrics or public health. One of the physicians shall be a doctor of osteopathy. Other members shall include a public health nurse, a social services worker and four consumers of health care. In making the appointments, the Governor shall consult with professional and other interested organizations.*] **Commission members must include individuals with clinical expertise and individuals who are consumers of health care.**

(2) Members of the Health Services Commission shall serve for a term of four years, at the pleasure of the Governor.

(3) Members shall receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties.

(4) The commission may establish such subcommittees of its members and other medical, economic or health services advisers as it determines to be necessary to assist the commission in the performance of its duties.

SECTION 17. ORS 414.720 is amended to read:

414.720. (1) The Health Services Commission shall conduct public hearings prior to making the report described in subsection (3) of this section. The commission shall solicit testimony and information from advocates representing seniors, persons with disabilities, mental health services consumers and low-income Oregonians, representatives of commercial carriers, representatives of small and large Oregon employers and providers of health care, including but not limited to physicians licensed to practice medicine, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

(2) The commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.

(3) Using a transparent process, the commission shall establish priorities from among health conditions, including physical, dental, vision, mental and chemical dependency, in 10 categories:

(a) Prevention;

(b) Pregnancy and childbirth;

(c) Acute life-threatening conditions;

(d) Acute non-life-threatening self-limiting conditions;

(e) Catastrophic conditions;

(f) Chronic life-threatening conditions;

(g) Chronic non-life-threatening conditions;

(h) End of life;

(i) Rehabilitation; and

(j) Elective conditions.

(4) The commission shall establish priorities among the categories and within each category, from the most important to the least important, based upon the comparative health benefit of treating each condition for optimizing the health of the population and based on criteria that have been publicly debated and agreed upon by the Oregon Health Fund Board including, but not limited to:

(a) Social values;

(b) Clinical effectiveness of the treatment of the condition to produce quality outcomes;

(c) The degree to which medical evidence exists to support the relationship between the treatment and the desired quality health outcome;

(d) The relative cost-effectiveness of drugs, procedures and technologies in terms of the health benefit for the entire population served; and

(e) Investments needed in nonclinical services and programs that have a bearing on the health of the population.

[*(3)*] **(5)** The commission shall report to the [*Governor a*] **Oregon Health Fund Board the** list of health [*services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to*] **conditions ranked by priority from the most important to the least important based upon the comparative health benefit of treatment of each condition for optimizing the health of** the entire population to be served. The list submitted by the commission pursuant to this subsection is not subject to alteration by any other state agency. The recommendation may include practice guidelines reviewed and adopted by the commission [*pursuant to subsection (4) of this section*].

[*(4) In order to encourage effective and efficient medical evaluation and treatment, the commission:*]

[*(a) May include clinical practice guidelines in its prioritized list of services. The commission shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical practice guidelines developed by the commission.*]

[*(b) Shall consider both the clinical effectiveness and cost-effectiveness of health services in determining their relative importance using peer-reviewed medical literature as defined in ORS 743.695.*]

[*(5) The commission shall make its report by July 1 of the year preceding each regular session of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Representatives and the President of the Senate.*]

[*(6) The commission may alter the list during interim only under the following conditions:*]

[*(a) Technical changes due to errors and omissions; and*]

[*(b) Changes due to advancements in medical technology or new data regarding health outcomes.*]

[*(7) If a service is deleted or added and no new funding is required, the commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the commission must report to the Emergency Board to request the funding.*]

[*(8) The report listing services to be provided pursuant to ORS 414.036, 414.042, 414.065, 414.107, 414.705 to 414.725 and 414.735 to 414.750 shall remain in effect from October 1 of the odd-numbered year through September 30 of the next odd-numbered year.*]

(6)(a) The Oregon Health Fund Board shall be responsible for supervising an independent actuarial process to determine the cost of treating each condition on the list to produce quality outcomes.

(b) The board must develop the assumptions used in the actuarial process with the involvement and input of affected persons including, but not limited to, consumers of health care, employers, hospitals, primary care physicians, specialists, nurse practitioners, mental health providers, dentists and providers from community health centers and rural health clinics.

(c) The board must base actuarial assumptions concerning utilization of services upon the most efficient and effective delivery system models producing quality outcomes, particularly for the management of chronic conditions.

(d) The actuarial assumptions developed by the board under paragraph (b) of this subsection must include the following:

(A) Providers must receive fair and reasonable payments that are stable and predictable for treating the covered set of essential health conditions to produce quality outcomes. Payments may include payment for other than face-to-face encounters. Payment levels must take into account the need to create incentives that ensure adequate provider capacity to meet the requirements of the most efficient and effective delivery system models producing quality outcomes.

(B) There must be value based cost-sharing for consumers, with higher cost-sharing burdens for the treatment of elective, discretionary conditions and conditions that are lower on the priority list, with lower or no cost sharing for the treatment of conditions that are higher on the priority list, particularly when the treatment is highly effective in producing quality outcomes.

(7) The Oregon Health Fund Board shall determine payment levels for the defined set of essential health conditions by:

(a) Dividing the Oregon Health Fund by the eligible population to arrive at a capitation

rate; and

(b) Applying the capitation rate to the list described in subsection (5) of this section.

SECTION 18. ORS 414.735 is amended to read:

414.735. **(1) If moneys accumulate in excess of the legislatively adopted budget for the Oregon Health Fund during a biennium, the Oregon Health Fund Board may authorize coverage for the treatment of additional health conditions from the list developed under section 13 of this 2007 Act.**

[*(1) If insufficient resources are available during a contract period:*]

[*(a) The population of eligible persons determined by law shall not be reduced.*]

(2) If the Oregon Health Fund is insufficient to provide treatment for the defined set of essential health conditions to all eligible persons during a biennium:

(a) The number, types or categories of persons may not be reduced by restricting eligibility requirements.

(b) The reimbursement rate for providers and [*plans*] **health care organizations** established under the contractual agreement shall not be reduced.

[*(2)*] **(3)** In the circumstances described in subsection [*(1)*] **(2)** of this section, [*reimbursement shall be adjusted by reducing the health services for the eligible population by eliminating services in the order of priority recommended by the Health Services Commission*] **the Oregon Health Fund Board may:**

(a) Reduce the total cost of treatment for the defined set of essential health conditions by eliminating or modifying the treatment of conditions from the list of conditions developed under ORS 414.720, starting with the least important and progressing toward the most important[.]**; or**

(b) Request an additional General Fund appropriation from the Legislative Assembly.

[*(3) The Department of Human Services shall obtain the approval of the Legislative Assembly or Emergency Board, if the Legislative Assembly is not in session, before instituting the reductions. In addition, providers contracting to provide health services under ORS 414.705 to 414.750 must be notified at least two weeks prior to any legislative consideration of such reductions. Any reductions made under this section shall take effect no sooner than 60 days following final legislative action approving the reductions.*]

SECTION 19. ORS 414.745 is amended to read:

414.745. Any health care provider or [*plan*] **health care organization** contracting to provide services to the eligible population under [*ORS 414.705 to 414.750*] **section 10 of this 2007 Act,** shall not be subject to criminal prosecution, civil liability or professional disciplinary action for failing to provide a service which the Legislative Assembly has not funded or **the Oregon Health Fund Board** has eliminated [*from its funding*] **from coverage** pursuant to ORS 414.735.

SECTION 20. ORS 414.709 is repealed.

SECTION 21. Sections 4, 10 and 11 of this 2007 Act, the amendments to ORS 414.707 and 414.735 by sections 15 and 18 of this 2007 Act, and the repeal of ORS 414.709 by section 20 of this 2007 Act become operative 90 days after receipt of congressional approval requested under section 10 of this 2007 Act.

SECTION 22. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.
