Senate Bill 860

Sponsored by COMMITTEE ON HEALTH CARE, HUMAN SERVICES AND RURAL HEALTH POLICY (at the request of Oregon Health Authority)

SUMMARY

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

Requires Oregon Health Authority to establish payment standards for hospital, ambulatory surgical center and certain health care professional services. Requires hospitals, ambulatory surgical centers and health care professionals to bill and accept as payment in full, in specified circumstances, payments made in accordance with uniform standards prescribed by authority. Applies to payments for services provided on or after January 1, 2013.

Requires insurer to defend claim of malpractice if claim is based on disclosure of adverse event by health practitioner to patient or patient's family. Applies to insurance policies issued or renewed on or after effective date of Act. Expands coverage of immunity from liability based on expression of regret or apology to include health care institution or facility and explanation of cause of adverse event.

Expands list of health professional regulatory boards subject to health care workforce data reporting to Office for Oregon Health Policy and Research.

Authorizes Department of Consumer and Business Services to adopt uniform standards for health care financial and administrative transactions of specified persons. Authorizes Oregon Health Authority to convene stakeholder work group to recommend standards for health care financial and administrative transactions and to report recommendations to department.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care; creating new provisions; amending ORS 676.410, 677.082, 731.036, 750.055 and 750.333; repealing sections 1192 and 1193, chapter 595, Oregon Laws 2009; and declaring an emergency.

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

UNIFORM PAYMENT METHODOLOGIES FOR HEALTH CARE

SECTION 1. (1) As used in this section and section 2 of this 2011 Act:

(a) "Health care professional" means a provider of health services whose fee is calculated using the resource-based relative value scale.

(b) "Resource-based relative value scale" means the payment scale for physician services established by the Centers for Medicare and Medicaid Services under 42 C.F.R. 414.22.

(2) The Oregon Health Authority shall prescribe by rule uniform fee-for service payment standards for hospital and ambulatory surgical center services that:

(a) Incorporate the most recent Medicare payment methodologies established by the Centers for Medicare and Medicaid Services for hospital and ambulatory surgical center services;

(b) Include payment standards for services that are not fully addressed by the Medicare payment methodologies; and

(c) Allow for the use of alternative payment methodologies including but not limited to pay-for-performance, bundled payments and capitation.

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) The authority shall prescribe by rule uniform fee-for-service payment standards for health care professionals that are based on the most recent Medicare resource-based relative value scale.

(4) In developing the standards described in this section, the authority shall convene and be advised by a work group consisting of providers, purchasers and consumers of the types of services that are the subject of the rulemaking.

SECTION 2. (1)(a) A hospital or ambulatory surgical center shall bill and accept as payment in full an amount determined in accordance with payment standards prescribed by the Oregon Health Authority under section 1 (2) of this 2011 Act.

(b) This subsection does not apply to Type A or Type B hospitals or rural critical access hospitals, all as described in ORS 442.470.

(2) A health care professional shall bill and accept as payment in full a fee determined in accordance with payment standards established by the authority under section 1 (3) of this 2011 Act.

SECTION 3. Sections 1 and 2 of this 2011 Act apply to payments for services that are provided on or after January 1, 2013.

DEFENSE OF MEDICAL MALPRACTICE CLAIMS

SECTION 4. Section 5 of this 2011 Act is added to and made a part of the Insurance Code.

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

(a) "Adverse event" means a negative consequence of patient care that is unanticipated, is usually preventable and results in or presents a significant risk of patient injury.

(b) "Claim" means a written demand for restitution for an injury alleged to have been caused by the medical negligence of a health practitioner or licensed health care facility.

(c) "Health practitioner" means a person described in ORS 31.740 (1).

(2) An insurer may not decline or refuse to defend a health practitioner or a health care facility against a claim arising from an adverse event for any reason that is based on the disclosure to the patient or the patient's family by the health practitioner or facility of the adverse event or information relating to the cause of the adverse event.

SECTION 6. ORS 677.082 is amended to read:

677.082. (1) For the purposes of any civil action against a person [*licensed by the Oregon Medical Board*], any expression of regret or apology made by or on behalf of the person, including an expression of regret or apology that is made in writing, orally or by conduct, does not constitute an admission of liability [*for any purpose*].

(2) A person who [*is licensed by the Oregon Medical Board, or any other person who*] makes an expression of regret or apology **or an individual who makes an expression of regret or apology** on behalf of a person [*who is licensed by the Oregon Medical Board*], may not be examined by deposition or otherwise in any civil or administrative proceeding, including any arbitration or mediation proceeding, with respect to an expression of regret or apology made by or on behalf of the person, including expressions of regret or apology that are made in writing, orally or by conduct.

(3) As used in this section:

(a) "Adverse event" has the meaning given that term in section 5 of this 2011 Act.

(b) "Expression of regret or apology" includes an explanation of the cause of an adverse event to:

(A) The patient affected by the adverse event;

(B) The family of the patient affected by the adverse event; or

(C) A health care representative or other individual authorized to make health care decisions on behalf of the patient affected by the adverse event.

(c) "Person" means:

(A) An individual who is licensed by the Oregon Medical Board; or

(B) An institution or a health care facility that employs or grants admitting privileges to an individual who is licensed by the Oregon Medical Board.

SECTION 7. Section 5 of this 2011 Act applies to insurance policies issued or renewed on or after the effective date of this 2011 Act.

HEALTH CARE WORKFORCE DATA REPORTING

SECTION 8. ORS 676.410 is amended to read:

676.410. (1) As used in this section, "healthcare workforce regulatory board" means [*the:*]

[*(a) Occupational Therapy Licensing Board;*]

[*(b) Oregon Medical Board;*]

[*(c) Oregon State Board of Nursing;*]

[*(d) Oregon Board of Dentistry;*]

[*(e) Physical Therapist Licensing Board;*]

[*(f) State Board of Pharmacy; and*]

[*(g) Board of Examiners of Licensed Dietitians*] **a health professional regulatory board as defined in ORS 676.160 with the exception of the:**

(a) State Mortuary and Cemetery Board; and

(b) Oregon State Veterinary Medical Examining Board.

(2)(a) An applicant for a license from a healthcare workforce regulatory board or renewal of a license by a healthcare workforce regulatory board shall provide the information prescribed by the Office for Oregon Health Policy and Research pursuant to subsection (3) of this section.

(b) Except as provided in subsection (4) of this section, a healthcare workforce regulatory board may not approve a subsequent application for a license or renewal of a license until the applicant provides the information.

(3) The Administrator for the Office for Oregon Health Policy and Research **and the Director of the Oregon Health Authority** shall collaborate with the healthcare workforce regulatory boards to adopt rules for the manner, **timing,** form and content for reporting, and the information that must be provided to a healthcare workforce regulatory board under subsection (2) of this section, which may include:

(a) Demographics, including race and ethnicity.

(b) Education information.

(c) License information.

(d) Employment information.

(e) Primary and secondary practice information.

(f) Anticipated changes in the practice.

(g) Languages spoken.

(4)(a) A healthcare workforce regulatory board shall report healthcare workforce information collected under subsection (2) of this section to the Office for Oregon Health Policy and Research.

(b) A healthcare workforce regulatory board shall keep confidential and not release personally identifiable data collected under this section for a person licensed, registered or certified by a board. This paragraph does not apply to the release of information to a law enforcement agency for investigative purposes or to the release to the Office for Oregon Health Policy and Research for state health planning purposes.

[*(5) The requirements of subsection (2) of this section apply to an applicant for issuance or renewal of a license who is or who is applying to become:*]

[*(a) An occupational therapist or certified occupational therapy assistant as defined in ORS 675.210;*]

[*(b) A physician as defined in ORS 677.010;*]

[*(c) A physician assistant as defined in ORS 677.495;*]

[*(d) A nurse or nursing assistant licensed or certified under ORS 678.010 to 678.410;*]

[*(e) A dentist or dental hygienist as defined in ORS 679.010;*]

[*(f) A physical therapist or physical therapist assistant as defined in ORS 688.010;*]

[*(g) A pharmacist or pharmacy technician as defined in ORS 689.005; or*]

[*(h) A licensed dietitian, as defined in ORS 691.405.*]

[*(6)*] **(5)** A healthcare workforce regulatory board may adopt rules as necessary to perform the board's duties under this section.

[*(7)*] **(6)** In addition to licensing fees that may be imposed by a healthcare workforce regulatory board, the Oregon Health Policy Board shall establish fees to be paid by applicants for issuance or renewal of licenses reasonably calculated to reimburse the actual cost of obtaining or reporting information as required by subsection (2) of this section.

SECTION 9. The amendments to ORS 676.410 by section 8 of this 2011 Act apply to an application for a license or for the renewal of a license on or after the effective date of this 2011 Act.

UNIFORM STANDARDS FOR HEALTH CARE TRANSACTIONS

SECTION 10. Section 11 of this 2011 Act is added to and made a part of the Insurance Code.

SECTION 11. (1) The Department of Consumer and Business Services may adopt by rule uniform standards applicable to persons listed in subsection (2) of this section for health care financial and administrative transactions.

(2) Except as provided in subsection (3) of this section, the uniform standards adopted under subsection (1) of this section apply to:

(a) Health insurers.

(b) Prepaid managed care health services organizations as defined in ORS 414.736.

(c) Third party administrators.

(d) Any person or public body that either individually or jointly establishes a self-insurance plan, program or contract including but not limited to persons and public bodies that are otherwise exempt from the Insurance Code under ORS 731.036.

(e) Health care clearinghouses or other entities that process or facilitate the processing of health care financial and administrative transactions from a nonstandard format to a standard format.

(f) Any other person identified by the Department of Consumer and Business Services

that processes health care financial and administrative transactions between a health care provider and an entity described in this subsection.

(3) The uniform standards adopted by the Department of Consumer and Business Services under subsection (1) of this section do not apply to the Oregon Health Authority or the Department of Human Services.

(4) In developing or updating the uniform standards adopted under subsection (1) of this section, the Department of Consumer and Business Services shall consider recommendations from the authority under section 12 of this 2011 Act.

SECTION 12. (1) The Oregon Health Authority may convene a stakeholder work group to recommend uniform standards for health care financial and administrative transactions.

(2) The authority shall report uniform standards recommended under subsection (1) of this section to the Department of Consumer and Business Services for consideration in the adoption of uniform standards by the department under section 11 of this 2011 Act.

SECTION 13. Uniform standards adopted by the Department of Consumer and Business Services under section 11 of this 2011 Act apply to financial and administrative transactions that occur on or after January 1, 2012.

SECTION 14. Sections 1192 and 1193, chapter 595, Oregon Laws 2009, are repealed.

SECTION 15. ORS 731.036 is amended to read:

731.036. **Except as specifically provided by law,** the Insurance Code does not apply to any of the following to the extent of the subject matter of the exemption:

(1) A bail bondsman, other than a corporate surety and its agents.

(2) A fraternal benefit society that has maintained lodges in this state and other states for 50 years prior to January 1, 1961, and for which a certificate of authority was not required on that date.

(3) A religious organization providing insurance benefits only to its employees, which organization is in existence and exempt from taxation under section 501(c)(3) of the federal Internal Revenue Code on September 13, 1975.

(4) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for tort liability in accordance with ORS 30.282.

(5) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for property damage in accordance with ORS 30.282.

(6) Cities, counties, school districts, community college districts, community college service districts or districts, as defined in ORS 198.010 and 198.180, that either individually or jointly insure for health insurance coverage, excluding disability insurance, their employees or retired employees, or their dependents, or students engaged in school activities, or combination of employees and dependents, with or without employee or student contributions, if all of the following conditions are met:

(a) The individual or jointly self-insured program meets the following minimum requirements:

(A) In the case of a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals;

(B) In the case of an individual public body program other than a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals; and

(C) In the case of a joint program of two or more public bodies, the number of covered em-

ployees and dependents and retired employees and dependents aggregates at least 1,000 individuals;

(b) The individual or jointly self-insured health insurance program includes all coverages and benefits required of group health insurance policies under ORS chapters 743 and 743A;

(c) The individual or jointly self-insured program must have program documents that define program benefits and administration;

(d) Enrollees must be provided copies of summary plan descriptions including:

(A) Written general information about services provided, access to services, charges and scheduling applicable to each enrollee's coverage;

(B) The program's grievance and appeal process; and

(C) Other group health plan enrollee rights, disclosure or written procedure requirements established under ORS chapters 743 and 743A;

(e) The financial administration of an individual or jointly self-insured program must include the following requirements:

(A) Program contributions and reserves must be held in separate accounts and used for the exclusive benefit of the program;

(B) The program must maintain adequate reserves. Reserves may be invested in accordance with the provisions of ORS chapter 293. Reserve adequacy must be calculated annually with proper actuarial calculations including the following:

(i) Known claims, paid and outstanding;

(ii) A history of incurred but not reported claims;

(iii) Claims handling expenses;

(iv) Unearned contributions; and

(v) A claims trend factor; and

(C) The program must maintain adequate reinsurance against the risk of economic loss in accordance with the provisions of ORS 742.065 unless the program has received written approval for an alternative arrangement for protection against economic loss from the Director of the Department of Consumer and Business Services;

(f) The individual or jointly self-insured program must have sufficient personnel to service the employee benefit program or must contract with a third party administrator licensed under ORS chapter 744 as a third party administrator to provide such services;

(g) The individual or jointly self-insured program shall be subject to assessment in accordance with ORS 735.614 and 743.951 and former enrollees shall be eligible for portability coverage in accordance with ORS 735.616;

(h) The public body, or the program administrator in the case of a joint insurance program of two or more public bodies, files with the Director of the Department of Consumer and Business Services copies of all documents creating and governing the program, all forms used to communicate the coverage to beneficiaries, the schedule of payments established to support the program and, annually, a financial report showing the total incurred cost of the program for the preceding year. A copy of the annual audit required by ORS 297.425 may be used to satisfy the financial report filing requirement; and

(i) Each public body in a joint insurance program is liable only to its own employees and no others for benefits under the program in the event, and to the extent, that no further funds, including funds from insurance policies obtained by the pool, are available in the joint insurance pool.

(7) All ambulance services.

(8) A person providing any of the services described in this subsection. The exemption under this

subsection does not apply to an authorized insurer providing such services under an insurance policy. This subsection applies to the following services:

(a) Towing service.

(b) Emergency road service, which means adjustment, repair or replacement of the equipment, tires or mechanical parts of a motor vehicle in order to permit the motor vehicle to be operated under its own power.

(c) Transportation and arrangements for the transportation of human remains, including all necessary and appropriate preparations for and actual transportation provided to return a decedent's remains from the decedent's place of death to a location designated by a person with valid legal authority under ORS 97.130.

(9)(a) A person described in this subsection who, in an agreement to lease or to finance the purchase of a motor vehicle, agrees to waive for no additional charge the amount specified in paragraph (b) of this subsection upon total loss of the motor vehicle because of physical damage, theft or other occurrence, as specified in the agreement. The exemption established in this subsection applies to the following persons:

(A) The seller of the motor vehicle, if the sale is made pursuant to a motor vehicle retail installment contract.

(B) The lessor of the motor vehicle.

(C) The lender who finances the purchase of the motor vehicle.

(D) The assignee of a person described in this paragraph.

(b) The amount waived pursuant to the agreement shall be the difference, or portion thereof, between the amount received by the seller, lessor, lender or assignee, as applicable, which represents the actual cash value of the motor vehicle at the date of loss, and the amount owed under the agreement.

(10) A self-insurance program for tort liability or property damage that is established by two or more affordable housing entities and that complies with the same requirements that public bodies must meet under ORS 30.282 (6). As used in this subsection:

(a) "Affordable housing" means housing projects in which some of the dwelling units may be purchased or rented, with or without government assistance, on a basis that is affordable to individuals of low income.

(b) "Affordable housing entity" means any of the following:

(A) A housing authority created under the laws of this state or another jurisdiction and any agency or instrumentality of a housing authority, including but not limited to a legal entity created to conduct a self-insurance program for housing authorities that complies with ORS 30.282 (6).

(B) A nonprofit corporation that is engaged in providing affordable housing.

(C) A partnership or limited liability company that is engaged in providing affordable housing and that is affiliated with a housing authority described in subparagraph (A) of this paragraph or a nonprofit corporation described in subparagraph (B) of this paragraph if the housing authority or nonprofit corporation:

(i) Has, or has the right to acquire, a financial or ownership interest in the partnership or limited liability company;

(ii) Has the power to direct the management or policies of the partnership or limited liability company;

(iii) Has entered into a contract to lease, manage or operate the affordable housing owned by the partnership or limited liability company; or

(iv) Has any other material relationship with the partnership or limited liability company.

(11) A community-based health care initiative approved by the Administrator of the Office for Oregon Health Policy and Research under ORS 735.723 operating a community-based health care improvement program approved by the administrator.

SECTION 16. ORS 750.055 is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992 and 731.870 **and sections 5 and 11 of this 2011 Act**.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.188, 743A.190 and 743A.192.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

(g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(h) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025

and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 17. ORS 750.333 is amended to read:

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652 and 731.804 to 731.992 **and sections 5 and 11 of this 2011 Act**.

(b) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.912, 743.917, 743A.012, 743A.020, 743A.052, 743A.064, 743A.080, 743A.100, 743A.104, 743A.110, 743A.144, 743A.170, 743A.175, 743A.184 and 743A.192.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048, 743A.058, 743A.066, 743A.068, 743A.070, 743A.084, 743A.088, 743A.090, 743A.105, 743A.140, 743A.141, 743A.148, 743A.168, 743A.180, 743A.188 and 743A.190. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

(h) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

(i) ORS 731.592 and 731.594.

(j) ORS 731.870.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

CAPTIONS

SECTION 18. The unit captions used in this 2011 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2011 Act.

EMERGENCY CLAUSE

SECTION 19. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.

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