

House Bill 2039

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of Governor Kate Brown for 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**.

Transfers to Public Employees' Benefit Board and Oregon Educators Benefit Board duty to conduct audit to determine health benefit plan enrollees' continued eligibility for coverage as spouses or dependents. Directs benefit boards to conduct audit at least once every five years.

A BILL FOR AN ACT

1
2 Relating to dependent eligibility review for public employee benefit plans; amending ORS 243.135
3 and 243.866.

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

5 **SECTION 1.** ORS 243.135, as amended by section 27, chapter 746, Oregon Laws 2017, is
6 amended to read:

7 243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
8 Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed
9 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
10 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
11 on:

12 (a) Employee choice among high quality plans;

13 (b) A competitive marketplace;

14 (c) Plan performance and information;

15 (d) Employer flexibility in plan design and contracting;

16 (e) Quality customer service;

17 (f) Creativity and innovation;

18 (g) Plan benefits as part of total employee compensation;

19 (h) The improvement of employee health; and

20 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
21 plan.

22 (2) The board may approve more than one carrier for each type of plan contracted for and of-
23 fered but the number of carriers shall be held to a number consistent with adequate service to eli-
24 gible employees and their family members.

25 (3) Where appropriate for a contracted and offered health benefit plan, the board shall provide
26 options under which an eligible employee may arrange coverage for family members who are not
27 enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board.
28 An eligible employee who declines coverage in a health benefit plan offered by the Public
29 Employees' Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse
30 or family member in another health benefit plan offered by the Public Employees' Benefit Board 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 the Oregon Educators Benefit Board may not be paid the employer contribution for the plan that
2 was declined.

3 (4) Payroll deductions for costs that are not payable by the state or a local government may be
4 made upon receipt of a signed authorization from the employee indicating an election to participate
5 in the plan or plans selected and the deduction of a certain sum from the employee's pay.

6 (5) In developing any health benefit plan, the board may provide an option of additional cover-
7 age for eligible employees and their family members at an additional cost or premium.

8 (6) Transfer of enrollment from one plan to another shall be open to all eligible employees and
9 their family members under rules adopted by the board. Because of the special problems that may
10 arise in individual instances under comprehensive group practice plan coverage involving acceptable
11 provider-patient relations between a particular panel of providers and particular eligible employees
12 and their family members, the board shall provide a procedure under which any eligible employee
13 may apply at any time to substitute a health service benefit plan for participation in a comprehen-
14 sive group practice benefit plan.

15 (7) The board shall evaluate a benefit plan that serves a limited geographic region of this state
16 according to the criteria described in subsection (1) of this section.

17 (8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by
18 the board that are designed to limit the growth in per-member expenditures for health services to
19 no more than 3.4 percent per year.

20 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
21 mium amounts paid for contracted health benefit plans to 3.4 percent.

22 (9) *[A carrier or third party administrator that contracts with the board to provide or administer*
23 *a health benefit plan shall, at least once each plan year,]* **At least once every five years, the board**
24 **shall** conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as
25 spouses or dependents or any other basis that would affect the cost of the premium for the plan.

26 (10) By January 1, 2023, the board shall spend at least 12 percent of its total medical expen-
27 ditures in self-insured health benefit plans on payments for primary care.

28 (11) No later than February 1 of each year, the board shall report to the Legislative Assembly
29 on the board's progress toward achieving the target of spending at least 12 percent of total medical
30 expenditures in self-insured health benefit plans on payments for primary care.

31 **SECTION 2.** ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, and sec-
32 tion 27, chapter 746, Oregon Laws 2017, is amended to read:

33 243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
34 Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed
35 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
36 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
37 on:

- 38 (a) Employee choice among high quality plans;
- 39 (b) A competitive marketplace;
- 40 (c) Plan performance and information;
- 41 (d) Employer flexibility in plan design and contracting;
- 42 (e) Quality customer service;
- 43 (f) Creativity and innovation;
- 44 (g) Plan benefits as part of total employee compensation;
- 45 (h) The improvement of employee health; and

1 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
2 plan.

3 (2) The board may approve more than one carrier for each type of plan contracted for and of-
4 fered but the number of carriers shall be held to a number consistent with adequate service to eli-
5 gible employees and their family members.

6 (3) Where appropriate for a contracted and offered health benefit plan, the board shall provide
7 options under which an eligible employee may arrange coverage for family members who are not
8 enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board.
9 An eligible employee who declines coverage in a health benefit plan offered by the Public
10 Employees' Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse
11 or family member in another health benefit plan offered by the Public Employees' Benefit Board or
12 the Oregon Educators Benefit Board may not be paid the employer contribution for the plan that
13 was declined.

14 (4) Payroll deductions for costs that are not payable by the state or a local government may be
15 made upon receipt of a signed authorization from the employee indicating an election to participate
16 in the plan or plans selected and the deduction of a certain sum from the employee's pay.

17 (5) In developing any health benefit plan, the board may provide an option of additional cover-
18 age for eligible employees and their family members at an additional cost or premium.

19 (6) Transfer of enrollment from one plan to another shall be open to all eligible employees and
20 their family members under rules adopted by the board. Because of the special problems that may
21 arise in individual instances under comprehensive group practice plan coverage involving acceptable
22 provider-patient relations between a particular panel of providers and particular eligible employees
23 and their family members, the board shall provide a procedure under which any eligible employee
24 may apply at any time to substitute a health service benefit plan for participation in a comprehen-
25 sive group practice benefit plan.

26 (7) The board shall evaluate a benefit plan that serves a limited geographic region of this state
27 according to the criteria described in subsection (1) of this section.

28 (8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by
29 the board that are designed to limit the growth in per-member expenditures for health services to
30 no more than 3.4 percent per year.

31 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
32 mium amounts paid for contracted health benefit plans to 3.4 percent.

33 (9) *[A carrier or third party administrator that contracts with the board to provide or administer*
34 *a health benefit plan shall, at least once each plan year,]* **At least once every five years, the board**
35 **shall** conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as
36 spouses or dependents or any other basis that would affect the cost of the premium for the plan.

37 (10) If the board spends less than 12 percent of its total medical expenditures in self-insured
38 health benefit plans on payments for primary care, the board shall implement a plan for increasing
39 the percentage of total medical expenditures spent on payments for primary care by at least one
40 percent each year.

41 (11) No later than February 1 of each year, the board shall report to the Legislative Assembly
42 on any plan implemented under subsection (10) of this section and on the board's progress toward
43 achieving the target of spending at least 12 percent of total medical expenditures in self-insured
44 health benefit plans on payments for primary care.

45 **SECTION 3.** ORS 243.866, as amended by section 28, chapter 746, Oregon Laws 2017, is

1 amended to read:

2 243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
3 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
4 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
5 phasis on:

- 6 (a) Employee choice among high-quality plans;
- 7 (b) Encouragement of a competitive marketplace;
- 8 (c) Plan performance and information;
- 9 (d) District and local government flexibility in plan design and contracting;
- 10 (e) Quality customer service;
- 11 (f) Creativity and innovation;
- 12 (g) Plan benefits as part of total employee compensation;
- 13 (h) Improvement of employee health; and
- 14 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
15 plan.

16 (2) The board may approve more than one carrier for each type of benefit plan offered, but the
17 board shall limit the number of carriers to a number consistent with adequate service to eligible
18 employees and family members who are not enrolled in another health benefit plan offered by the
19 board or the Public Employees' Benefit Board. An eligible employee who declines coverage in a
20 health benefit plan offered by the Oregon Educators Benefit Board or the Public Employees' Benefit
21 Board and who is enrolled as a spouse or family member in another health benefit plan offered by
22 the Oregon Educators Benefit Board or the Public Employees' Benefit Board may not be paid the
23 employer contribution for the plan that was declined.

24 (3) When appropriate, the board shall provide options under which an eligible employee may
25 arrange coverage for family members under a benefit plan.

26 (4) A district or a local government shall provide that payroll deductions for benefit plan costs
27 that are not payable by the district or local government may be made upon receipt of a signed au-
28 thorization from the employee indicating an election to participate in the benefit plan or plans se-
29 lected and allowing the deduction of those costs from the employee's pay.

30 (5) In developing any benefit plan, the board may provide an option of additional coverage for
31 eligible employees and family members at an additional premium.

32 (6) The board shall adopt rules providing that transfer of enrollment from one benefit plan to
33 another is open to all eligible employees and family members. Because of the special problems that
34 may arise involving acceptable provider-patient relations between a particular panel of providers
35 and a particular eligible employee or family member under a comprehensive group practice benefit
36 plan, the board shall provide a procedure under which any eligible employee may apply at any time
37 to substitute another benefit plan for participation in a comprehensive group practice benefit plan.

38 (7) An eligible employee who is retired is not required to participate in a health benefit plan
39 offered under this section in order to obtain dental benefit plan coverage. The board shall establish
40 by rule standards of eligibility for retired employees to participate in a dental benefit plan.

41 (8) The board shall evaluate a benefit plan that serves a limited geographic region of this state
42 according to the criteria described in subsection (1) of this section.

43 (9)(a) The board shall use payment methodologies in self-insured health benefit plans offered by
44 the board that are designed to limit the growth in per-member expenditures for health services to
45 no more than 3.4 percent per year.

1 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
 2 mium amounts paid for contracted health benefit plans to 3.4 percent.

3 (10) *[A carrier or third party administrator that contracts with the board to provide or administer*
 4 *a health benefit plan shall, at least once each plan year,]* **At least once every five years, the board**
 5 **shall** conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as
 6 spouses or dependents or any other basis that would affect the cost of the premium for the plan.

7 (11) By January 1, 2023, the board shall spend at least 12 percent of its total medical expen-
 8 ditures in self-insured health benefit plans on payments for primary care.

9 (12) No later than February 1 of each year, the board shall report to the Legislative Assembly
 10 on the board's progress toward achieving the target of spending at least 12 percent of total medical
 11 expenditures on payments for primary care.

12 **SECTION 4.** ORS 243.866, as amended by section 17, chapter 489, Oregon Laws 2017, and sec-
 13 tion 28, chapter 746, Oregon Laws 2017, is amended to read:

14 243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
 15 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
 16 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
 17 phasis on:

- 18 (a) Employee choice among high-quality plans;
- 19 (b) Encouragement of a competitive marketplace;
- 20 (c) Plan performance and information;
- 21 (d) District and local government flexibility in plan design and contracting;
- 22 (e) Quality customer service;
- 23 (f) Creativity and innovation;
- 24 (g) Plan benefits as part of total employee compensation;
- 25 (h) Improvement of employee health; and
- 26 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
 27 plan.

28 (2) The board may approve more than one carrier for each type of benefit plan offered, but the
 29 board shall limit the number of carriers to a number consistent with adequate service to eligible
 30 employees and family members who are not enrolled in another health benefit plan offered by the
 31 board or the Public Employees' Benefit Board. An eligible employee who declines coverage in a
 32 health benefit plan offered by the Oregon Educators Benefit Board or the Public Employees' Benefit
 33 Board and who is enrolled as a spouse or family member in another health benefit plan offered by
 34 the Oregon Educators Benefit Board or the Public Employees' Benefit Board may not be paid the
 35 employer contribution for the plan that was declined.

36 (3) When appropriate, the board shall provide options under which an eligible employee may
 37 arrange coverage for family members under a benefit plan.

38 (4) A district or a local government shall provide that payroll deductions for benefit plan costs
 39 that are not payable by the district or local government may be made upon receipt of a signed au-
 40 thorization from the employee indicating an election to participate in the benefit plan or plans se-
 41 lected and allowing the deduction of those costs from the employee's pay.

42 (5) In developing any benefit plan, the board may provide an option of additional coverage for
 43 eligible employees and family members at an additional premium.

44 (6) The board shall adopt rules providing that transfer of enrollment from one benefit plan to
 45 another is open to all eligible employees and family members. Because of the special problems that

1 may arise involving acceptable provider-patient relations between a particular panel of providers
2 and a particular eligible employee or family member under a comprehensive group practice benefit
3 plan, the board shall provide a procedure under which any eligible employee may apply at any time
4 to substitute another benefit plan for participation in a comprehensive group practice benefit plan.

5 (7) An eligible employee who is retired is not required to participate in a health benefit plan
6 offered under this section in order to obtain dental benefit plan coverage. The board shall establish
7 by rule standards of eligibility for retired employees to participate in a dental benefit plan.

8 (8) The board shall evaluate a benefit plan that serves a limited geographic region of this state
9 according to the criteria described in subsection (1) of this section.

10 (9)(a) The board shall use payment methodologies in self-insured health benefit plans offered by
11 the board that are designed to limit the growth in per-member expenditures for health services to
12 no more than 3.4 percent per year.

13 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
14 mium amounts paid for contracted health benefit plans to 3.4 percent.

15 (10) *[A carrier or third party administrator that contracts with the board to provide or administer*
16 *a health benefit plan shall, at least once each plan year,]* **At least once every five years, the board**
17 **shall** conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as
18 spouses or dependents or any other basis that would affect the cost of the premium for the plan.

19 (11) If the board spends less than 12 percent of its total medical expenditures in self-insured
20 health benefit plans on payments for primary care, the board shall implement a plan for increasing
21 the percentage of total medical expenditures spent on payments for primary care by at least one
22 percent each year.

23 (12) No later than February 1 of each year, the board shall report to the Legislative Assembly
24 on any plan implemented under subsection (11) of this section and on the board's progress toward
25 achieving the target of spending at least 12 percent of total medical expenditures on payments for
26 primary care.

27