

HOUSE AMENDMENTS TO HOUSE BILL 2266

By COMMITTEE ON RULES

June 4

1 In line 2 of the printed bill, before the period insert “; creating new provisions; amending ORS
2 243.135, 243.256, 243.866 and 243.879; and declaring an emergency”.

3 Delete lines 4 through 10 and insert:

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

6 “243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
7 Employees’ Benefit Board, the board shall contract for a health benefit plan or plans best designed
8 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
9 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
10 on:

11 “(a) Employee choice among high quality plans;

12 “(b) A competitive marketplace;

13 “(c) Plan performance and information;

14 “(d) Employer flexibility in plan design and contracting;

15 “(e) Quality customer service;

16 “(f) Creativity and innovation;

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

18 “(h) The improvement of employee health; and

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

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

24 “(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide
25 options under which an eligible employee may arrange coverage for family members [*who are not*
26 *enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board.*

27 *An eligible employee who declines coverage in a health benefit plan offered by the Public Employees’*
28 *Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse or family*
29 *member in another health benefit plan offered by the Public Employees’ Benefit Board or the Oregon*
30 *Educators Benefit Board may not be paid the employer contribution for the plan that was declined].*

31 **The board shall impose a surcharge in an amount determined by the board on an eligible**
32 **employee who arranges coverage for the employee’s spouse or dependent under this sub-**
33 **section if the spouse or dependent has access to medical coverage as an employee in another**
34 **health benefit plan offered by the board or the Oregon Educators Benefit Board.**

35 “(4) Payroll deductions for costs that are not payable by the state or a local government may

1 be made upon receipt of a signed authorization from the employee indicating an election to partic-
2 ipate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

3 "(5) In developing any health benefit plan, the board may provide an option of additional cov-
4 erage for eligible employees and their family members at an additional cost or premium.

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

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

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

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

19 "(9) [A carrier or third party administrator that contracts with the board to provide or administer
20 a health benefit plan shall, at least once each plan year,] **As frequently as is recommended as a**
21 **commercial best practice by consultants engaged by the board, the board shall** conduct an
22 audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents
23 or any other basis that would affect the cost of the premium for the plan.

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

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

29 "**SECTION 2.** ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, and
30 section 27, chapter 746, Oregon Laws 2017, is amended to read:

31 "243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
32 Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed
33 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
34 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
35 on:

36 "(a) Employee choice among high quality plans;

37 "(b) A competitive marketplace;

38 "(c) Plan performance and information;

39 "(d) Employer flexibility in plan design and contracting;

40 "(e) Quality customer service;

41 "(f) Creativity and innovation;

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

43 "(h) The improvement of employee health; and

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

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

4 “(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide
5 options under which an eligible employee may arrange coverage for family members [*who are not*
6 *enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board.*
7 *An eligible employee who declines coverage in a health benefit plan offered by the Public Employees’*
8 *Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse or family*
9 *member in another health benefit plan offered by the Public Employees’ Benefit Board or the Oregon*
10 *Educators Benefit Board may not be paid the employer contribution for the plan that was declined*].
11 **The board shall impose a surcharge in an amount determined by the board on an eligible**
12 **employee who arranges coverage for the employee’s spouse or dependent under this sub-**
13 **section if the spouse or dependent has access to medical coverage as an employee in another**
14 **health benefit plan offered by the board or the Oregon Educators Benefit Board.**

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

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

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

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

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

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

34 “(9) [*A carrier or third party administrator that contracts with the board to provide or administer*
35 *a health benefit plan shall, at least once each plan year,*] **As frequently as is recommended as a**
36 **commercial best practice by consultants engaged by the board, the board shall** conduct an
37 audit of the health benefit plan enrollees’ continued eligibility for coverage as spouses or dependents
38 or any other basis that would affect the cost of the premium for the plan.

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

43 “(11) No later than February 1 of each year, the board shall report to the Legislative Assembly
44 on any plan implemented under subsection (10) of this section and on the board’s progress toward
45 achieving the target of spending at least 12 percent of total medical expenditures in self-insured

1 health benefit plans on payments for primary care.

2 “**SECTION 3.** ORS 243.866, as amended by section 28, chapter 746, Oregon Laws 2017, is
3 amended to read:

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

8 “(a) Employee choice among high-quality plans;

9 “(b) Encouragement of a competitive marketplace;

10 “(c) Plan performance and information;

11 “(d) District and local government flexibility in plan design and contracting;

12 “(e) Quality customer service;

13 “(f) Creativity and innovation;

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

15 “(h) Improvement of employee health; and

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

18 “(2) The board may approve more than one carrier for each type of benefit plan offered, but the
19 board shall limit the number of carriers to a number consistent with adequate service to eligible
20 employees and family members [*who are not enrolled in another health benefit plan offered by the*
21 *board or the Public Employees’ Benefit Board. An eligible employee who declines coverage in a health*
22 *benefit plan offered by the Oregon Educators Benefit Board or the Public Employees’ Benefit Board*
23 *and who is enrolled as a spouse or family member in another health benefit plan offered by the Oregon*
24 *Educators Benefit Board or the Public Employees’ Benefit Board may not be paid the employer con-*
25 *tribution for the plan that was declined]. **The board shall impose a surcharge in an amount de-***

26 **termined by the board on an eligible employee who arranges coverage for the employee’s**
27 **spouse or dependent under this subsection if the spouse or dependent has access to medical**
28 **coverage as an employee in another health benefit plan offered by the board or the Public**
29 **Employees’ Benefit Board.**

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

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

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

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

44 “(7) An eligible employee who is retired is not required to participate in a health benefit plan
45 offered under this section in order to obtain dental benefit plan coverage. The board shall establish

1 by rule standards of eligibility for retired employees to participate in a dental benefit plan.

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

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

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

9 “(10) [A carrier or third party administrator that contracts with the board to provide or administer
10 a health benefit plan shall, at least once each plan year,] **As frequently as is recommended as a**
11 **commercial best practice by consultants engaged by the board, the board shall** conduct an
12 audit of the health benefit plan enrollees’ continued eligibility for coverage as spouses or dependents
13 or any other basis that would affect the cost of the premium for the plan.

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

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

19 “**SECTION 4.** ORS 243.866, as amended by section 17, chapter 489, Oregon Laws 2017, and
20 section 28, chapter 746, Oregon Laws 2017, is amended to read:

21 “243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
22 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
23 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
24 phasis on:

25 “(a) Employee choice among high-quality plans;

26 “(b) Encouragement of a competitive marketplace;

27 “(c) Plan performance and information;

28 “(d) District and local government flexibility in plan design and contracting;

29 “(e) Quality customer service;

30 “(f) Creativity and innovation;

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

32 “(h) Improvement of employee health; and

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

35 “(2) The board may approve more than one carrier for each type of benefit plan offered, but the
36 board shall limit the number of carriers to a number consistent with adequate service to eligible
37 employees and family members [*who are not enrolled in another health benefit plan offered by the*
38 *board or the Public Employees’ Benefit Board. An eligible employee who declines coverage in a health*
39 *benefit plan offered by the Oregon Educators Benefit Board or the Public Employees’ Benefit Board*
40 *and who is enrolled as a spouse or family member in another health benefit plan offered by the Oregon*
41 *Educators Benefit Board or the Public Employees’ Benefit Board may not be paid the employer con-*
42 *tribution for the plan that was declined]. **The board shall impose a surcharge in an amount de-***
43 **termined by the board on an eligible employee who arranges coverage for the employee’s**
44 **spouse or dependent under this subsection if the spouse or dependent has access to medical**
45 **coverage as an employee in another health benefit plan offered by the board or the Public**

1 **Employees' Benefit Board.**

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

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

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

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

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

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

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

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

26 “(10) [A carrier or third party administrator that contracts with the board to provide or administer
27 a health benefit plan shall, at least once each plan year,] **As frequently as is recommended as a**
28 **commercial best practice by consultants engaged by the board, the board shall** conduct an
29 audit of the health benefit plan enrollees’ continued eligibility for coverage as spouses or dependents
30 or any other basis that would affect the cost of the premium for the plan.

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

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

39 “**SECTION 5.** ORS 243.256, as amended by section 29, chapter 746, Oregon Laws 2017, is
40 amended to read:

41 “243.256. (1) A carrier that contracts with the Public Employees’ Benefit Board to provide to
42 eligible employees and their dependents a benefit plan that reimburses the cost of inpatient or out-
43 patient hospital services or supplies shall reimburse a claim for the cost of a hospital service or
44 supply that is covered by, or is similar to a service or supply that is covered by, the Medicare
45 program in an amount that does not exceed:

1 “(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare
2 for the service or supply; or

3 “(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medi-
4 care for the service or supply.

5 “(2) A self-insurance program administered by a third party administrator that is offered by the
6 board to eligible employees and their dependents and that reimburses the cost of inpatient or out-
7 patient hospital services or supplies shall reimburse a claim for the cost of a hospital service or
8 supply that is covered by, or is similar to a service or supply that is covered by, the Medicare
9 program in an amount that does not exceed:

10 “(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare
11 for the service or supply; or

12 “(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medi-
13 care for the service or supply.

14 “(3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section may
15 not charge to or collect from the patient or a person who is financially responsible for the patient
16 an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other
17 than cost sharing amounts authorized by the terms of the health benefit plan.

18 “(4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis,
19 the payment method used must take into account the limits specified in subsections (1) and (2) of this
20 section. Such payment methods include, but are not limited to:

21 “(a) Value-based payments;

22 “(b) Capitation payments; and

23 “(c) Bundled payments.

24 “(5) This section does not apply to reimbursements paid by a carrier or third party administrator
25 to:

26 “(a) A type A or type B hospital as described in ORS 442.470;

27 “(b) A rural critical access hospital as defined in ORS 315.613; [or]

28 “(c) A hospital:

29 “(A) Located in a county with a population of less than 70,000 on August 15, 2017;

30 “(B) Classified as a sole community hospital by the Centers for Medicare and Medicaid Services;
31 and

32 “(C) With Medicare payments composing at least 40 percent of the hospital’s total annual pa-
33 tient revenue[.]; **or**

34 “**(d) A hospital located outside of this state.**

35 “(6) This section does not require a health benefit plan offered by the board to reimburse claims
36 using a fee-for-service payment method.

37 “**SECTION 6.** ORS 243.879, as amended by section 31, chapter 746, Oregon Laws 2017, is
38 amended to read:

39 “243.879. (1) A carrier that contracts with the Oregon Educators Benefit Board to provide to
40 eligible employees and their dependents a benefit plan that reimburses the cost of inpatient or out-
41 patient hospital services or supplies shall reimburse a claim for the cost of a hospital service or
42 supply that is covered by, or is similar to a service or supply that is covered by, the Medicare
43 program in an amount that does not exceed:

44 “(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare
45 for the service or supply; or

1 “(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medi-
2 care for the service or supply.

3 “(2) A self-insurance program administered by a third party administrator that is offered by the
4 board to eligible employees and their dependents and that reimburses the cost of inpatient or out-
5 patient hospital services or supplies shall reimburse a claim for the cost of a hospital service or
6 supply that is covered by, or is similar to a service or supply that is covered by, the Medicare
7 program in an amount that does not exceed:

8 “(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare
9 for the service or supply; or

10 “(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medi-
11 care for the service or supply.

12 “(3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section may
13 not charge to or collect from the patient or a person who is financially responsible for the patient
14 an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other
15 than cost sharing amounts authorized by the terms of the health benefit plan.

16 “(4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis,
17 the payment method used must take into account the limits specified in subsections (1) and (2) of this
18 section. Such payment methods include, but are not limited to:

19 “(a) Value-based payments;

20 “(b) Capitation payments; and

21 “(c) Bundled payments.

22 “(5) This section does not apply to reimbursements paid by a carrier or third party administrator
23 to:

24 “(a) A type A or type B hospital as described in ORS 442.470;

25 “(b) A rural critical access hospital as defined in ORS 315.613; [or]

26 “(c) A hospital:

27 “(A) Located in a county with a population of less than 70,000 on August 15, 2017;

28 “(B) Classified as a sole community hospital by the Centers for Medicare and Medicaid Services;

29 and

30 “(C) With Medicare payments composing at least 40 percent of the hospital’s total annual pa-
31 tient revenue[.]; or

32 “(d) A hospital located outside of this state.

33 “(6) This section does not require a health benefit plan offered by the board to reimburse claims
34 using a fee-for-service payment method.

35 “**SECTION 7. The Oregon Health Authority shall report to the committees or interim**
36 **committees of the Legislative Assembly related to health care no later than December 31,**
37 **2019, on:**

38 “(1) **Actions and strategies employed by the Public Employees’ Benefit Board and the**
39 **Oregon Educators Benefit Board to limit the growth in per-member expenditures for health**
40 **services to 3.4 percent per year or less;**

41 “(2) **Challenges identified by the boards in limiting the growth in per-member expen-**
42 **ditures for health services to 3.4 percent per year;**

43 “(3) **Steps taken to maximize the state’s purchasing power and reduce the total cost of**
44 **delivering care; and**

45 “(4) **An overview of renewal rates from the upcoming and previous benefit years.**

1 **“SECTION 8. (1) The Public Employees’ Benefit Board shall impose a surcharge under**
2 **ORS 243.135 (3) for plan years beginning on or after January 1, 2021.**

3 **“(2) The Oregon Educators Benefit Board shall impose a surcharge under ORS 243.866 (2)**
4 **for plan years beginning on or after January 1, 2020.**

5 **“SECTION 9. This 2019 Act being necessary for the immediate preservation of the public**
6 **peace, health and safety, an emergency is declared to exist, and this 2019 Act takes effect**
7 **on its passage.”.**

8
