SENATE AMENDMENTS TO A-ENGROSSED SENATE BILL 770

By JOINT COMMITTEE ON WAYS AND MEANS

June 21

On page 1 of the printed A-engrossed bill, delete lines 4 through 10 and delete pages 2 through 11 and insert:

"**SECTION 1. Definitions. As used in sections 1 to 7 of this 2019 Act:**

"(1) 'Group practice' means a single legal entity consisting of individual providers organized as a partnership, professional corporation, limited liability company, foundation, nonprofit corporation, faculty practice plan or similar association:

"(a) In which each individual provider uses office space, facilities, equipment and personnel shared with other individual providers to deliver medical care, consultation, diagnosis, treatment or other services that the provider routinely delivers in the provider's practice;

"(b) For which substantially all of the services delivered by the individual providers are delivered on behalf of the group practice and billed as services provided by the group practice;

"(c) For which substantially all of the payments to the group practice are to reimburse the cost of services provided by the individual providers in the group practice;

"(d) In which the overhead expenses of, and the income from, the group practice are shared among the individual providers in the group practice in accordance with methods agreed to by the individual providers who are members of the group practice; and

"(e) That is a unified business with consolidated billing, accounting and financial reporting and a centralized decision-making body that represents the individual providers who are members of the group practice.

"(2) 'Individual provider' means a health care practitioner who is licensed, certified or registered in this state or who is licensed, certified or registered to provide care in another state or country.

"(3) 'Institutional provider' means a single legal entity that is:

"(a) A health care facility as defined in ORS 442.015;

"(b) A comprehensive outpatient rehabilitation facility;

"(c) A home health agency as defined in ORS 443.014; or

"(d) A hospice program as defined in ORS 443.850.

"(4) 'Provider' means an individual provider, an institutional provider or a group practice.

"(5) 'Single payer health care financing system' means a universal system used by the state for paying the cost of health care services or goods in which:

"(a) Institutional providers are paid directly for health care services or goods by the state or are paid by an administrator that does not bear risk in its contracts with the state;

"(b) Group practices are paid directly for health care services or goods by the state or are paid by an administrator that does not bear risk in its contracts with the state, by the

employer of the group practice or by an institutional provider; and

"(c) Individual providers are paid directly for health care services or goods by the state, by their employers, by an administrator that does not bear risk in its contracts with the state, by an institutional provider or by a group practice.

"**SECTION 2. Establishment of the Task Force on Universal Health Care. (1) The Task Force on Universal Health Care is established to recommend the design of the Health Care for All Oregon Plan, a universal health care system, administered by the Health Care for All Oregon Board, that is equitable, affordable and comprehensive, provides high quality health care and is publicly funded and available to every individual residing in Oregon.**

"(2) The task force consists of the following 20 members:

"(a) The President of the Senate shall appoint two members from among members of the Senate, including one member from the majority party and one member from the minority party.

"(b) The Speaker of the House of Representatives shall appoint two members from among members of the House of Representatives, including one member from the majority party and one member from the minority party.

"(c) The Governor shall appoint 13 members, subject to confirmation by the Senate under ORS 171.562 and 171.565, who reside in this state and who:

"(A) Represent, to the greatest extent practicable:

"(i) Diverse social identities, including but not limited to individuals who identify by geography, race, ethnicity, sex, gender nonconformance, sexual orientation, economic status, disability or health status; and

"(ii) Diverse areas of expertise, based on knowledge and experience, including but not limited to patient advocacy, receipt of medical assistance, management of a business that offers health insurance to the business's employees, public health, organized labor, provision of health care or owning a small business;

"(B) Represent, at a minimum, the following areas of expertise acquired by education, vocation or personal experience:

"(i) Rural health;

"(ii) Quality assurance and health care accountability;

"(iii) Fiscal management and change management;

"(iv) Social services;

"(v) Public health services;

"(vi) Medical and surgical services;

"(vii) Alternative therapy services;

"(viii) Services for persons with disabilities; and

"(ix) Nursing services;

"(C) Include at least one member who has an active license to provide health care in this state;

"(D) Include at least one member who has an active license to provide mental or behavioral health care in this state;

"(E) Include at least one member who has expertise, based on knowledge and experience, in advocating for health care equity; and

"(F) Include at least one member who has personal experience in seeking and receiving health care in this state to treat complex or multiple chronic illnesses or disabilities.

"(d) The Director of the Oregon Health Authority, or the director's designee, who is a nonvoting member.

"(e) The Director of the Department of Consumer and Business Services, or the director's designee, who is a nonvoting member.

"(f) A member of the Association of Oregon Counties, selected by the association, who is a nonvoting member.

"(3) In making the appointments under subsection (2)(c) of this section, the Governor shall ensure that there is no disproportionate influence by any individual, organization, government, industry, business or profession in any decision-making by the task force and no actual or potential conflicts of interest.

"(4) A majority of the voting members of the task force constitutes a quorum for the transaction of business.

"(5) Official action by the task force requires the approval of a majority of the voting members of the task force.

"(6) The task force shall elect one of its members to serve as chairperson and one to serve as vice chairperson.

"(7) If there is a vacancy for any cause, the appointing authority shall make an appointment to become immediately effective.

"(8) The task force shall meet at times and places specified by the call of the chairperson or of a majority of the voting members of the task force.

"(9) The task force may adopt rules necessary for the operation of the task force.

"(10)(a) The task force shall establish an advisory committee to provide input from a consumer perspective and, to the greatest extent practicable, from the diverse social identities described in subsection (2)(c)(A)(i) of this section.

"(b) The following qualifications must be possessed by the membership of the advisory committee, such that at least one member:

"(A) Has experience in seeking or receiving health care in this state to address one or more serious medical conditions or disabilities.

"(B) Is enrolled in health insurance offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board or represents public employees.

"(C) Is enrolled in employer-sponsored health insurance, group health insurance or a self-insured health plan offered by an employer.

"(D) Is enrolled in commercial insurance purchased without any employer contribution.

"(E) Receives medical assistance.

"(F) Is Enrolled in Medicare.

"(G) Is a parent or guardian of a child enrolled in the Children's Health Insurance Program.

"(H) Is enrolled in the Federal Employees Health Benefit Program.

"(I) Is enrolled in TRICARE.

"(J) Receives care from the United States Department of Veterans Affairs Veterans Health Administration.

"(K) Receives care from the Indian Health Service.

"(c) Members of the advisory committee are entitled to compensation and reimbursement of actual and necessary travel expenses incurred in the performance of the members' official duties in the manner and amount provided in ORS 292.495.

"(11) The task force may establish additional advisory or technical committees the task force considers necessary. The committees may be continuing or temporary. The task force shall determine the representation, membership, terms and organization of the committees and shall appoint the members of the committees.

"(12) The Legislative Policy and Research Director shall provide staff support to the task force.

"(13) The task force may apply for public or private grants from nonprofit organizations for the costs of research.

"(14) Members of the Legislative Assembly appointed to the task force are nonvoting members of the task force and may act in an advisory capacity only.

"(15) Members of the task force are entitled to compensation and actual and necessary travel and other expenses incurred by the members in the performance of official duties in the manner and amount as provided in ORS 292.495.

"(16) Members of advisory or technical committees, other than the advisory committee established in subsection (10) of this section, are not entitled to compensation but, in the discretion of the task force, may be reimbursed for actual and necessary travel and other expenses incurred by the members of the advisory or technical committees in the performance of official duties in the manner and amount provided in ORS 292.495.

"(17) All agencies of state government, as defined in ORS 174.111, are directed to assist the task force in the performance of the duties of the task force and, to the extent permitted by laws relating to confidentiality, to furnish information and advice the members of the task force consider necessary to perform their duties.

"SECTION 3. Purpose. The Task Force on Universal Health Care shall produce findings and recommendations, reported to the Legislative Assembly as provided in sections 6 and 8 of this 2019 Act, for a well-functioning single payer health care financing system that is responsive to the needs and expectations of the residents of this state by:

"(1) Improving the health status of individuals, families and communities;

"(2) Defending against threats to the health of the residents of this state;

"(3) Protecting individuals from the financial consequences of ill health;

"(4) Providing equitable access to person-centered care;

"(5) Removing cost as a barrier to accessing health care;

"(6) Removing any financial incentive for a health care practitioner to provide care to one patient rather than another;

"(7) Making it possible for individuals to participate in decisions affecting their health and the health system;

"(8) Establishing measurable health care goals and guidelines that align with other state and federal health standards; and

"(9) Promoting continuous quality improvement and fostering interorganizational collaboration.

"SECTION 4. Values. The Task Force on Universal Health Care, in developing its recommendations to the Legislative Assembly for the Health Care for All Oregon Plan, shall consider, at a minimum, the following values:

"(1) Health care, as a fundamental element of a just society, is to be secured for all individuals on an equitable basis by public means, similar to public education, public safety and other public infrastructure;

"(2) Access to a distribution of health care resources and services according to each individual's needs and location within the state should be available. Race, color, national origin, age, disability, wealth, income, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion or sex, including sex stereotyping, gender identity, sexual orientation and pregnancy and related medical conditions, including termination of pregnancy, may not create any barriers to health care nor disparities in health outcomes due to access to care;

"(3) The components of the system must be accountable and fully transparent to the public with regard to information, decision-making and management through meaningful public participation in decisions affecting people's health care; and

"(4) Funding for the Health Care for All Oregon Plan is a public trust and any savings or excess revenue are to be returned to that public trust.

"SECTION 5. Principles. The Task Force on Universal Health Care, in developing its recommendations for the Health Care for All Oregon Plan, shall consider at a minimum the following principles:

"(1) A participant in the plan may choose any individual provider who is licensed, certified or registered in this state or any group practice.

"(2) The plan may not discriminate against any individual provider who is licensed, certified or registered in this state to provide services covered by the plan and who is acting within the provider's scope of practice.

"(3) A participant and the participant's provider shall determine, within the scope of services covered within each category of care and within the plan's parameters for standards of care and requirements for prior authorization, whether a treatment is medically necessary or medically appropriate for that participant.

"(4) The plan will cover services from birth to death, based on evidence-informed decisions as determined by the Health Care for All Oregon Board.

"SECTION 6. Scope of the design of the Health Care for All Oregon Plan by the Task Force on Universal Health Care. (1) The design of the Health Care for All Oregon Plan recommended by the Task Force on Universal Health Care to the Legislative Assembly under subsection (4) of this section must:

"(a) Adhere to the values and principles described in sections 4 and 5 of this 2019 Act;

"(b) Be a single payer health care financing system;

"(c) Ensure that individuals who receive services from the United States Department of Veterans Affairs Veterans Health Administration or the Indian Health Services may be enrolled in the plan while continuing to receive the services;

"(d) Equitably and uniformly include all residents in the plan without decreasing the ability of any individual to obtain affordable health care coverage if the individual moves out of this state by obtaining a waiver of federal requirements that pose barriers to achieving the goal or by adopting other approaches; and

"(e) Preserve the coverage of the health services currently required by Medicare, Medicaid, the Children's Health Insurance Program, the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), Oregon's medical assistance program and any other state or federal program.

"(2) In designing the plan, the task force shall:

"(a) Develop cost estimates for the plan, including but not limited to cost estimates for:

"(A) The approach recommended for achieving the result described in subsection (1)(d) of this section; and

"(B) The payment method designed by the task force under section 7 (2) of this 2019 Act in designing the plan;

"(b) Consider how the plan will impact the structure of existing state and local boards and commissions, counties, cities and special service districts, as well as the United States Government, other states and Indian tribes;

"(c) Consider the issues raised in the report entitled 'A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon' produced in response to section 1, chapter 712, Oregon Laws 2013, and section 2, chapter 725, Oregon Laws 2015;

"(d) Investigate other states' attempts at providing universal coverage and using single payer health care financing systems, including the outcomes of the attempts; and

"(e) Take into account the work by existing health care professional boards and commissions to incorporate important aspects of the work of the health care professional boards and commissions into recommendations for the plan.

"(3) In developing recommendations to the Legislative Assembly for the plan, the task force shall engage in a public process to solicit public input on the elements of the plan described in subsections (1), (4), (7) and (8) of this section. The public process must:

"(a) Ensure input from individuals in rural and underserved communities and from individuals in communities that experience health care disparities;

"(b) Solicit public comments statewide while providing to the public evidence-based information developed by the task force about the health care costs of a single payer health care financing system, including the cost estimates developed under subsection (2) of this section, as compared to the current system; and

"(c) Solicit the perspectives of:

"(A) Individuals throughout the range of communities that experience health care disparities;

"(B) A range of businesses, based on industry and employer size;

"(C) Individuals whose insurance coverage represents a range of current insurance types and individuals who are uninsured or underinsured; and

"(D) Individuals with a range of health care needs, including individuals needing disability services and long term care services who have experienced the financial and social effects of policies requiring them to exhaust a large portion of their resources before qualifying for long term care services paid for by the medical assistance program.

"(4) The task force shall make findings and recommendations for the design of the plan and the Health Care for All Oregon Board and submit a report of its findings and recommendations to the Legislative Assembly as provided in ORS 192.245. The task force's recommendations must be succinct statements and include actions and timelines, the degree of consensus and the priority of each recommendation, based on urgency and importance. The task force may defer any recommendations to be determined by the board. The report must include, but is not limited to, the following:

"(a) The governance and leadership of the board, specifically:

"(A) The composition and representation of the membership of the board, appointed or otherwise selected using an open and equitable selection process;

"(B) The statutory authority the board must have to establish policies, guidelines, mandates, incentives and enforcement needed to develop a highly effective and responsive single payer health care financing system;

"(C) The ethical standards and the enforcement of the ethical standards for members of the board such that there are the most rigorous protections and prohibitions from actual or perceived economic conflicts of interest; and

"(D) The steps for ensuring that there is no disproportionate influence by any individual, organization, government, industry, business or profession in any decision-making by the board;

"(b) A list of federal and state laws, rules, state contracts or agreements, court actions or decisions that may facilitate, constrain, or prevent implementation of the plan and an explanation of how the federal or state laws, rules, state contracts or agreements, court actions or decisions may facilitate or constrain or prevent implementation;

"(c) The plan's economic sustainability, operational efficiency and cost control measures that include, but are not limited to, the following:

"(A) A financial governance system supported by relevant legislation, financial audit and public expenditure reviews and clear operational rules to ensure efficient use of public funds; and

"(B) Cost control features such as multistate purchasing;

"(d) Features of the plan that are necessary to continue to receive federal funding that is currently available to the state and estimates of the amount of the federal funding that will be available;

"(e) Fiduciary requirements for the revenue generated to fund the plan, including, but not limited to, the following:

"(A) A dedicated fund, separate and distinct from the General Fund, that is held in trust for the residents of this state;

"(B) Restrictions to be authorized by the board on the use of the trust fund;

"(C) A process for creating a reserve fund by retaining moneys in the trust fund if, over the course of a year, revenue exceeds costs; and

"(D) Required accounting methods that eliminate the potential for misuse of public funds, detect inaccuracies in provider reimbursement and use the most rigorous generally accepted accounting principles, including annual external audits and audits at the time of each transition in the board's executive management;

"(f) Requirements for the purchase of reinsurance;

"(g) Bonding authority that may be necessary;

"(h) The board's role in workforce recruitment, retention and development;

"(i) A process for the board to develop statewide goals, objectives and ongoing review;

"(j) The appropriate relationship between the board and regional or local authorities regarding oversight of health activities, health care systems and providers to promote community health reinvestment, equity and accountability;

"(k) Criteria to guide the board in determining which health care services are necessary for the maintenance of health, the prevention of health problems, the treatment or rehabilitation of health conditions and long term and respite care. Criteria may include, but are not limited to, the following:

"(A) Whether the services are cost-effective and based on evidence from multiple

sources;

"(B) Whether the services are currently covered by the health benefit plans offered by the Oregon Educators Benefit Board and the Public Employees' Benefit Board;

"(C) Whether the services are designated as effective by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices, the Health Resources and Services Administration's Bright Futures Program, the Institute of Medicine Committee on Preventive Services for Women or the Health Evidence Review Commission;

"(D) Whether the evidence on the effectiveness of services comes from peer-reviewed medical literature, existing assessments and recommendations from state and federal boards and commissions and other peer-reviewed sources; and

"(E) Whether the services are based on information provided by the Traditional Health Workers Commission established in ORS 413.600;

"(L) A process to track and resolve complaints, grievances and appeals, including establishing an Office of the Patient Advocate;

"(m) Options for transition planning, including an impact analysis on existing health systems, providers and patient relationships;

"(n) Options for incorporating cost containment measures such as prior approval and prior authorization requirements and the effect of such measures on equitable access to quality diagnosis and care;

"(o) The methods for reimbursing providers for the cost of care as described in section 7 (2) of this 2019 Act and recommendations regarding the appropriate reimbursement for the cost of services provided to plan participants when they are traveling outside this state; and

"(p) Recommendations for long term care services and supports that are tailored to each individual's needs based on an assessment. The services and supports may include:

"(A) Long term nursing services provided by an institutional provider or in a community-based setting;

"(B) A broad spectrum of long term services and supports, including home and community-based settings or other noninstitutional settings;

"(C) Services that meet the physical, mental and social needs of individuals while allowing them maximum possible autonomy and maximum civic, social and economic participation;

"(D) Long term services and supports that are not based on the individual's type of disability, level of disability, service needs or age;

"(E) Services provided in the least restrictive setting appropriate to the individual's needs;

"(F) Services provided in a manner that allows persons with disabilities to maintain their independence, self-determination and dignity;

"(G) Services and supports that are of equal quality and accessibility in every geographic region of this state; and

"(H) Services and supports that give the individual the opportunity to direct the services.

"(5) In developing recommendations for long term care services and supports for the plan under subsection (4)(p) of this section, the task force shall convene an advisory committee that includes:

"(a) Persons with disabilities who receive long term services and supports;

"(b) Older adults who receive long term services and supports;

"(c) Individuals representing persons with disabilities and older adults;

"(d) Members of groups that represent the diversity, including by gender, race and economic status, of individuals who have disabilities;

"(e) Providers of long term services and supports, including in-home care providers who are represented by organized labor, and family attendants and caregivers who provide long term services and supports; and

"(f) Academics and researchers in relevant fields of study.

"(6) Notwithstanding subsection (4)(p) of this section, the task force may explore the effects of excluding long term care services from the plan, including but not limited to the social, financial and administrative costs.

"(7) The task force's report to the Legislative Assembly must include:

"(a) The waivers of federal laws or other federal approval that will be necessary to enable a person who is a resident of this state and who has other coverage that is not subject to state regulation to enroll in the plan without jeopardizing eligibility for the other coverage if the person moves out of this state;

"(b) Estimates of the savings and expenditure increases under the plan, relative to the current health care system, including but not limited to:

"(A) Savings from eliminating waste in the current system and from administrative simplification, fraud reduction, monopsony power, simplification of electronic documentation and other factors that the task force identifies;

"(B) Savings from eliminating the cost of insurance that currently provides medical benefits that would be provided through the plan; and

"(C) Increased costs due to providing better health care to more individuals than under the current health care system;

"(c) Estimates of the expected health care expenditures under the plan, compared to the current health care system, reported in categories similar to the National Health Expenditure Accounts compiled by the Centers for Medicare and Medicaid Services, including, at a minimum:

"(A) Personal health care expenditures;

"(B) Health consumption expenditures; and

"(C) State health expenditures;

"(d) Estimates of how much of the expenditures on the plan will be made from moneys currently spent on health care in this state from both state and federal sources and redirected or utilized, in an equitable and comprehensive manner, to the plan;

"(e) Estimates of the amount, if any, of additional state revenue that will be required;

"(f) Results of the task force's evaluation of the impact on individuals, communities and the state if the current level of health care spending continues without implementing the plan, using existing reports and analysis where available; and

"(g) A description of how the Health Care for All Oregon Board or another entity may enhance:

"(A) Access to comprehensive, high quality, patient-centered, patient-empowered, equitable and publicly funded health care for all individuals;

"(B) Financially sustainable and cost-effective health care for the benefit of businesses, families, individuals and state and local governments;

"(C) Regional and community-based systems integrated with community programs to contribute to the health of individuals and communities;

"(D) Regional planning for cost-effective, reasonable capital expenditures that promote regional equity;

"(E) Funding for the modernization of public health, under ORS 431.001 to 431.550, as an integral component of cost efficiency in an integrated health care system; and

"(F) An ongoing and deepening collaboration with Indian tribes and other organizations providing health care that will not be under the authority of the board.

"(8)(a) The task force's findings and recommendations regarding revenue for the plan, including redirecting existing health care moneys under subsection (7)(d) of this section, must be ranked according to explicit criteria, including the degree to which an individual, class of individuals or organization would experience an increase or decrease in the direct or indirect financial burden or whether they would experience no change. Revenue options may include, but are not limited to, the following:

"(A) The redirection of current public agency expenditures;

"(B) An employer payroll tax based on progressive principles that protect small businesses and that tend to preserve or enhance federal tax expenditures for Oregon employers that pay the costs of their employees' health care; and

"(C) A dedicated revenue stream based on progressive taxes that do not impose a burden on individuals who would otherwise qualify for medical assistance.

"(b) The task force may explore the effect of means-tested copayments or deductibles, including but not limited to the effect of increased administrative complexity and the resulting costs that cause patients to delay getting necessary care, resulting in more severe consequences for their health.

"(9) The task force's recommendations must ensure:

"(a) Public access to state, regional and local reports and forecasts of revenue expenditures;

"(b) That the reports and forecasts are accurate, timely, of sufficient detail and presented in a way that is understandable to the public to inform policy making and the allocation or reallocation of public resources; and

"(c) That the information can be used to evaluate programs and policies, while protecting patient confidentiality.

"SECTION 7. General nature of the system to be evaluated. (1) The Health Care for All Oregon Plan designed by the Task Force on Universal Health Care shall allow participation by any individual who:

"(a) Resides in this state;

"(b) Is a nonresident who works full time in this state and contributes to the plan; or

"(c) Is a nonresident who is a dependent of an individual described in paragraph (a) or (b) of this subsection.

"(2) Providers shall be paid as follows or using an alternative method that is similarly equitable and cost-effective:

"(a) Individual providers licensed in this state shall be paid:

"(A) On a fee-for-services basis;

"(B) As employees of institutional providers or members of group practices that are reimbursed with global budgets; or

"(C) As individual providers in group practices that receive capitation payments for providing outpatient services as permitted by paragraph (d) of this subsection.

"(b) Institutional providers shall be paid with global budgets that include separate capital budgets, determined through regional planning, and operational budgets.

"(c) Budgets shall be determined for individual hospitals and not for entities that own multiple hospitals, clinics or other providers of health care services or goods.

"(d) A group practice may be reimbursed with capitation payments if the group practice:

"(A) Primarily uses individual providers in the group practice to deliver care in the group practice's facilities;

"(B) Does not use capitation payments to reimburse the cost of hospital services; and

"(C) Does not offer financial incentives to individual providers in the group practice based on the utilization of services.

"(3) The task force's recommendations shall address issues related to the provision of services to nonresidents who receive services in this state and to plan participants who receive services outside this state.

"(4) The task force's recommendations for the duties of the Health Care for All Oregon Board and the details of the Health Care for All Oregon Plan must ensure, by considering the following factors, that patients are empowered to protect their health, their rights and their privacy:

"(a) Access to patient advocates who are responsible to the patient and maintain patient confidentiality and whose responsibilities include but are not limited to addressing concerns about providers and helping patients navigate the process of obtaining medical care;

"(b) Access to culturally and linguistically appropriate care and service;

"(c) The patient's ability to obtain needed care when a treating provider is unable or unwilling to provide the care;

"(d) Paying providers to complete forms or perform other administrative functions to assist patients in qualifying for disability benefits, family medical leave or other income supports; and

"(e) The patient's access to and control of medical records, including:

"(A) Empowering patients to control access to their medical records and obtain independent second opinions, unless there are clear medical reasons not to do so;

"(B) Requiring that a patient or the patient's designee be provided a complete copy of the patient's health records promptly after every interaction or visit with a provider;

"(C) Ensuring that the copy of the health records provided to a patient includes all data used in the care of that patient; and

"(D) Requiring that the patient or the patient's designee provide approval before any forwarding of the patient's data to, or access of the patient's data by, family members, caregivers, other providers or researchers.

"SECTION 8. Task Force timeline. (1) The members of the Task Force on Universal Health Care shall be appointed no later than May 31, 2020.

"(2) No later than September 30, 2020, the Legislative Policy and Research Office shall begin preparing a work plan for the task force.

"(3) The task force shall submit a report containing its findings and recommendations for the design of the Health Care for All Oregon Plan and the Health Care for All Oregon Board to the 2021 regular session of the Legislative Assembly.

"SECTION 9. Plan for a Medicaid Buy-In program or a public option. (1) The Oregon Health Authority shall develop a plan for a Medicaid Buy-In program or a public option to

provide an affordable health care option to all Oregon residents, with the primary focus being Oregon residents who do not have access to health care. To the extent feasible, the plan must:

"(a) Have no net cost to the state;

"(b) Provide a comprehensive package of benefits that are, at a minimum, equivalent to the benefits offered by qualified plans offered through the health insurance exchange;

"(c) Impose no more than minimal cost sharing, deductibles or copayments;

"(d) Take into account the impact on the distribution of risk in the health insurance market;

"(e) Encourage the utilization of premium tax credits available under section 36B of the Internal Revenue Code and other subsidies available under federal law;

"(f) Maximize the receipt of federal funds to support the costs of the program or option;

"(g) Utilize the coordinated care organization health care delivery model; and

"(h) Utilize the coordinated care organization provider networks to the extent possible without destabilizing the networks.

"(2) No later than May 1, 2020, the authority shall report to the Legislative Assembly, in the manner provided in ORS 192.245, the plan developed in accordance with subsection (1) of this section including:

"(a) A discussion of potential eligibility requirements for the Medicaid Buy-In program or public option, as well as the implications of limiting or not limiting eligibility in various ways;

"(b) Options for Medicaid Buy-In programs or public options targeted to specific populations including, but not limited to:

"(A) Residents with household incomes above 400 percent and below 600 percent of the federal poverty guidelines who are unable to afford health insurance offered by the resident's employer;

"(B) Residents who regularly cycle through enrolling and disenrolling in medical assistance and employer-sponsored health insurance; or

"(C) Other groups that face significant barriers to accessing affordable, quality health care;

"(c) Recommendations for legislative changes necessary to implement the plan; and

"(d) Any federal approval that will be required to implement the plan, such as demonstration projects under section 1115 of the Social Security Act, a state plan amendment or a waiver for state innovation under 42 U.S.C. 18052.

"SECTION 10. Sections 1 to 9 of this 2019 Act are repealed on January 2, 2022.

"SECTION 11. Appropriation. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2019, out of the General Fund, the amount of $1,174,816, which may be expended for carrying out sections 2 to 9 of this 2019 Act.

"SECTION 12. Captions. The section captions used in this 2019 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 2019 Act.

"SECTION 13. Emergency clause. This 2019 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2019 Act takes effect on its passage.".

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