HOUSE AMENDMENTS TO A-ENGROSSED HOUSE BILL 4016

By COMMITTEE ON RULES

February 25

On page 1 of the printed A-engrossed bill, line 2, after "ORS" delete the rest of the line and delete line 3 and insert "443.001, 676.630, 676.635, 690.005, 690.015, 743A.064, 743B.001 and 743B.425 and section 8, chapter 629, Oregon Laws 2019; and declaring an emergency.".

After line 4, insert:

"**ESTHETICS**".

On page 5, delete lines 7 and 8 and insert:

"**PRESCRIPTION DRUG COVERAGE**

"**SECTION 6.** ORS 743A.064 is amended to read:

"743A.064. **(1) As used in this section, 'urgent medical condition' means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.**

"[*(1)*] **(2)** All health insurance policies that provide a prescription drug benefit, except those policies in which coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this subsection, must include coverage for prescription drugs**:**

"(a) Dispensed by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic**; and**

"(b) Prescribed and dispensed by a licensed pharmacist if the State Board of Pharmacy or any state law authorizes the drug to be prescribed and dispensed by pharmacists licensed in this state.

"**(3) The coverage described in subsection (2)(b) of this section must include reimbursement of a pharmacist's reasonable fees for consulting with a patient.**

"[*(2)*] **(4)** The coverage required by subsection [*(1)*] **(2)** of this section is subject to the terms and conditions of the prescription drug benefit provided under the policy**, which may include a condition that a pharmacist prescribing a drug under subsection (2)(b) of this section document the patient visit and certify that the pharmacist made a reasonable attempt to inform the patient's primary care provider of the prescription**.

"[*(3) As used in this section, 'urgent medical condition' means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.*]

"**(5) This section is exempt from ORS 743A.001.**

"**SECTION 7.** ORS 743B.425 is amended to read:

"743B.425. (1) [*In reimbursing the cost of medication prescribed for the purpose of treating opioid or opiate withdrawal,*] An insurer offering a health benefit plan as defined in ORS 743B.005 may not**:**

"(a) Require prior authorization [*of payment during*] **for:**

"(A) The first 30 days of [*treatment*] **medication prescribed for the purpose of treating opioid or opiate withdrawal; or**

"(B) Post-exposure prophylaxes antiretroviral drugs; or

"(b) Restrict the reimbursement for medication-assisted treatments or drugs described in this subsection to in-network pharmacists or pharmacies.

"(2) This section is not subject to ORS 743A.001.

"(3) [*Nothing in this section shall be interpreted to*] **This section does not** prohibit**:**

"(a) Prior authorization for reimbursement for payment for prescribing opioids or opiates for purposes other than medical management or treatment of opioid or opiate abuse or addiction**; or**

"(b) Utilization review including, but not limited to, formularies or limits on quantities.

"**SECTION 8.** ORS 743B.001 is amended to read:

"743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, **743B.425,** 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550 and 743B.555 and section 2, chapter 771, Oregon Laws 2013:

"(1) 'Adverse benefit determination' means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

"(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

"(b) Rescission or cancellation of a policy or certificate;

"(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

"(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate;

"(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225; or

"(f) Denial, in whole or in part, of a request for prior authorization.

"(2) 'Authorized representative' means an individual who by law or by the consent of a person may act on behalf of the person.

"(3) 'Credit card' has the meaning given that term in 15 U.S.C. 1602.

"(4) 'Electronic funds transfer' has the meaning given that term in ORS 293.525.

"(5) 'Enrollee' has the meaning given that term in ORS 743B.005.

"(6) 'Essential community provider' has the meaning given that term in rules adopted by the Department of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 18031.

"(7) 'Grievance' means:

"(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

"(A) In writing, for an internal appeal or an external review; or

"(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

"(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

"(A) Availability, delivery or quality of a health care service;

"(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

"(C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

"(8) 'Health benefit plan' has the meaning given that term in ORS 743B.005.

"(9) 'Independent practice association' means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 731.098, to provide health care services to group members.

"(10) 'Insurer' includes a health care service contractor as defined in ORS 750.005.

"(11) 'Internal appeal' means a review by an insurer of an adverse benefit determination made by the insurer.

"(12) 'Managed health insurance' means any health benefit plan that:

"(a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

"(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

"(13) 'Medical services contract' means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. 'Medical services contract' does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

"(14)(a) 'Preferred provider organization insurance' means any health benefit plan that:

"(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

"(B) Does not require an enrollee to use the preferred network of providers in order to receive benefits under the plan; and

"(C) Creates financial incentives for an enrollee to use the preferred network of providers by providing an increased level of benefits.

"(b) 'Preferred provider organization insurance' does not mean a health benefit plan that has as its sole financial incentive a hold harmless provision under which providers in the preferred

network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

"(15) 'Prior authorization' means a determination by an insurer upon request by a provider or an enrollee, prior to the provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the health care requested. 'Prior authorization' does not include referral approval for evaluation and management services between providers.

"(16)(a) 'Provider' means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

"(b) With respect to the statutes governing the billing for or payment of claims, 'provider' also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.

"(17) 'Utilization review' means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care items, services, procedures or settings.

"**SECTION 9.** ORS 743B.001, as amended by section 12, chapter 284, Oregon Laws 2019, is amended to read:

"743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, **743B.425,** 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550 and 743B.555:

"(1) 'Adverse benefit determination' means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

"(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

"(b) Rescission or cancellation of a policy or certificate;

"(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

"(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate;

"(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225; or

"(f) Denial, in whole or in part, of a request for prior authorization.

"(2) 'Authorized representative' means an individual who by law or by the consent of a person may act on behalf of the person.

"(3) 'Credit card' has the meaning given that term in 15 U.S.C. 1602.

"(4) 'Electronic funds transfer' has the meaning given that term in ORS 293.525.

"(5) 'Enrollee' has the meaning given that term in ORS 743B.005.

"(6) 'Essential community provider' has the meaning given that term in rules adopted by the Department of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 18031.

"(7) 'Grievance' means:

"(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

"(A) In writing, for an internal appeal or an external review; or

"(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

"(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

"(A) Availability, delivery or quality of a health care service;

"(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

"(C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

"(8) 'Health benefit plan' has the meaning given that term in ORS 743B.005.

"(9) 'Independent practice association' means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 731.098, to provide health care services to group members.

"(10) 'Insurer' includes a health care service contractor as defined in ORS 750.005.

"(11) 'Internal appeal' means a review by an insurer of an adverse benefit determination made by the insurer.

"(12) 'Managed health insurance' means any health benefit plan that:

"(a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

"(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

"(13) 'Medical services contract' means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. 'Medical services contract' does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

"(14)(a) 'Preferred provider organization insurance' means any health benefit plan that:

"(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

"(B) Does not require an enrollee to use the preferred network of providers in order to receive benefits under the plan; and

"(C) Creates financial incentives for an enrollee to use the preferred network of providers by providing an increased level of benefits.

"(b) 'Preferred provider organization insurance' does not mean a health benefit plan that has

as its sole financial incentive a hold harmless provision under which providers in the preferred network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

"(15) 'Prior authorization' means a determination by an insurer upon request by a provider or an enrollee, prior to the provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the health care requested. 'Prior authorization' does not include referral approval for evaluation and management services between providers.

"(16)(a) 'Provider' means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

"(b) With respect to the statutes governing the billing for or payment of claims, 'provider' also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.

"(17) 'Utilization review' means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care items, services, procedures or settings.

"**SECTION 10. The amendments to ORS 743A.064 and 743B.425 by sections 6 and 7 of this 2020 Act apply to policies and certificates issued, renewed or extended on or after January 1, 2021.**

"**SENIOR EMERGENCY MEDICAL SERVICES**

"**SECTION 11. (1) As used in this section:**

"(a) 'Long term care facility' has the meaning given that term in ORS 442.015.

"(b) 'Residential care facility' has the meaning given that term in ORS 443.400.

"(c) 'Senior emergency medical services' means services provided by an emergency medical services provider, as defined in ORS 682.025, to residents of a long term care facility or residential care facility.

"(2)(a) The Senior Emergency Medical Services Innovation Program is established in the Department of Human Services. The purpose of the program is to select, provide funding to and monitor local public sector pilot projects that:

"(A) Provide innovative strategies for addressing the emergency medical services needs of this state's increasing number of aging residents who receive care and services in residential care facilities and long term care facilities;

"(B) Encourage the efficient and appropriate use of senior emergency medical services;

"(C) Reduce the overall costs of senior emergency medical services while promoting quality emergency medical services; and

"(D) Encourage unique community-based responses to challenges faced by local communities in meeting their residents' needs for senior emergency medical services.

"(b) The department shall provide funding to a pilot project described in this subsection from moneys deposited in the Quality Care Fund established under ORS 443.001.

"(3) The Senior Emergency Medical Services Advisory Council is established consisting of the following eight members appointed by the Governor:

"(a) One member representing long term care facilities;

"(b) One member representing residential care facilities;

"(c) One member who is a nurse or clinician in a long term care facility or a residential care facility;

"(d) One member representing an urban or suburban fire department or a city fire department that provides emergency medical services;

"(e) One member representing a rural fire protection district organized under ORS chapter 478;

"(f) One member who enters into agreements with a public sector entity to provide emergency medical services;

"(g) One member who is a physician licensed under ORS chapter 677 or other health care practitioner with expertise in emergency medical services; and

"(h) One member representing the Oregon Health Authority who has expertise in emergency medical services and trauma response.

"(4) The council shall advise and make recommendations to the Department of Human Services on:

"(a) Minimum standards and data reporting requirements for pilot projects funded through the program;

"(b) The application process and timelines for the consideration of applications for funding of pilot projects;

"(c) The criteria for the selection of pilot projects to participate in the program; and

"(d) Other factors identified by the council as likely to facilitate successful pilot projects.

"(5) A majority of the members of the council constitutes a quorum for the transaction of business.

"(6) Official action by the council requires the approval of a majority of the members of the council.

"(7) The council shall elect one of its members to serve as chairperson.

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

"(9) The council shall meet at times and places specified by the call of the chairperson or of a majority of the members of the council.

"(10) The council may adopt rules necessary for the operation of the council.

"(11) The department shall submit a report, in the manner provided in ORS 192.245, on the pilot projects selected for the program, the success achieved by each pilot project in meeting the goals of the program described in subsection (2) of this section and any recommendations for legislative changes necessary to improve the emergency services provided throughout this state.

"(12) The department shall submit the report described in subsection (11) of this section to the authority for consideration and review prior to submitting the report as described in subsection (11) of this section.

"(13) The department shall provide staff support to the council.

"(14) Members of the council are not entitled to compensation or reimbursement for expenses and serve as volunteers on the council.

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

"**SECTION 12.** **(1) As used in this section:**

"(a) 'Emergency medical services provider' has the meaning given that term in ORS 682.025.

"(b) 'Local government' has the meaning given that term in ORS 174.116.

"(c) 'Long term care facility' has the meaning given that term in ORS 442.015.

"(d) 'Residential care facility' has the meaning given that term in ORS 443.400.

"(2) The governing body of a local government may not enact or enforce any charter provision, ordinance, resolution or other regulation that:

"(a) Regulates the care or services and supports provided to a patient or resident of a long term care facility or residential care facility, that are subject to regulation by the Department of Human Services under state or federal law, or pursuant to rules adopted by the department; or

"(b) Imposes fees or other requirements that apply exclusively to long term care facilities or residential care facilities and are not generally applicable to business entities operating within the jurisdiction of the local government.

"(3) Subsection (2) of this section does not apply to:

"(a) Local government authority provided by state law, including but not limited to a local public health authority; or

"(b) Laws that impose a fine, fee, charge or sanction against long term care facilities or residential care facilities that contact an emergency medical services provider to provide lift assist services to a resident who has fallen and who the long term care facility or residential care facility knows, or reasonably should have known, does not require the services of an emergency medical services provider.

"**SECTION 13.** ORS 443.001 is amended to read:

"443.001. The Quality Care Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Quality Care Fund shall be credited to the Quality Care Fund. Moneys in the fund are continuously appropriated to the Department of Human Services and the Oregon Health Authority for**:**

"(1) Training, technical assistance, quality improvement initiatives and licensing activities to ensure that high standards for quality of care are met in accordance with rules adopted with respect to:

"[*(1)*] **(a)** A long term care facility as defined in ORS 442.015;

"[*(2)*] **(b)** A residential facility as defined in ORS 443.400, including but not limited to an assisted living facility; and

"[*(3)*] **(c)** An adult foster home as defined in ORS 443.705[*.*]**; and**

"(2) Purposes of section 11 (2) of this 2020 Act.

"**SECTION 14.** ORS 443.001, as amended by section 13 of this 2020 Act, is amended to read:

"443.001. The Quality Care Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Quality Care Fund shall be credited to the Quality Care Fund. Moneys in the fund are continuously appropriated to the Department of Human Services and the Oregon Health Authority for[*:*]

"[*(1)*] training, technical assistance, quality improvement initiatives and licensing activities to ensure that high standards for quality of care are met in accordance with rules adopted with respect to:

"[*(a)*] **(1)** A long term care facility as defined in ORS 442.015;

"[*(b)*] **(2)** A residential facility as defined in ORS 443.400, including but not limited to an assisted living facility; and

"[*(c)*] **(3)** An adult foster home as defined in ORS 443.705**.**[*; and*]

"[*(2) Purposes of section 11 (2) of this 2020 Act.*]

"**SECTION 15. The amendments to ORS 443.001 by section 14 of this 2020 Act become operative on January 2, 2024.**

"**SECTION 16. Sections 11 and 12 of this 2020 Act are repealed on January 2, 2024.**

"TASK FORCE ON UNIVERSAL HEALTH CARE

"**SECTION 17.** Section 8, chapter 629, Oregon Laws 2019, is amended to read:

"**Sec. 8.** (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)**(a) The task force shall report to the committees of the Legislative Assembly related to health during the 2021 regular session of the Legislative Assembly on the progress in developing its findings and recommendations in accordance with section 6 (4), chapter 629, Oregon Laws 2019, and any work that remains and the timeline for completion of the work.**

"(b) No later than November 1, 2021, the task force shall submit a **final** 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*] **in accordance with section 6 (4), chapter 629, Oregon Laws 2019, to the interim committees of the Legislative Assembly related to health**.

"CAPTIONS

"**SECTION 18. The unit captions used in this 2020 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 2020 Act.**

"EMERGENCY CLAUSE

"**SECTION 19. This 2020 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2020 Act takes effect on its passage.**".
