

# House Bill 4039

Sponsored by Representative WEBER (Pre-session filed.)

## SUMMARY

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

Modifies financial requirements for coordinated care organization expenditures on social determinants of health and health equity.

Requires Oregon Health Authority to expend on social determinants of health and health equity amount equal to or greater than three percent of authority's expenses in administering fee-for-service program in previous calendar year and to annually report expenditures to interim committees of Legislative Assembly related to health.

Prohibits authority from adopting rules that restrict coordinated care organization distributions or other expenditures above 200 percent of minimum required risk-based capital.

Declares emergency, effective on passage.

## A BILL FOR AN ACT

1  
2 Relating to coordinated care organizations; creating new provisions; amending ORS 414.572 and  
3 415.011; and declaring an emergency.

4 Whereas the Legislative Assembly has identified the role of coordinated care organizations in  
5 investing in the social determinants of health and health equity through community-based invest-  
6 ments; and

7 Whereas there is a need for consistent, sustainable investments in community benefit initiatives  
8 to address the social determinants of health and health equity efforts for every member of a coord-  
9 inated care organization, regardless of the profitability of the coordinated care organization; and

10 Whereas financing of community benefit initiatives should be easy to understand, transparent  
11 and consistent across all coordinated care organizations; and

12 Whereas investments in the social determinants of health and health equity need to be  
13 community-driven and supported by the coordinated care organizations with local data, needs and  
14 conditions driving the investment strategies; and

15 Whereas it is vitally important for community providers and partners to share financial risk for  
16 the health outcomes of coordinated care organization members; and

17 Whereas the Legislative Assembly has identified the inclusion of social determinants of health  
18 and health equity as part of medical expenditures by coordinated care organizations if approved by  
19 the Centers for Medicare and Medicaid Services; and

20 Whereas COVID-19 has highlighted the need for coordinated care organizations to have reserve  
21 requirements that ensure solvency but also allow flexibility for transitioning capital to address other  
22 needs; now, therefore,

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

24 **SECTION 1. Section 2 of this 2022 Act is added to and made a part of ORS chapter 414.**

25 **SECTION 2. The Oregon Health Authority shall prescribe by rule the types of expen-**  
26 **ditures that meet the criteria in ORS 414.572 (1)(b)(C) including, but not limited to, any of**  
27 **the following:**

**NOTE:** Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

1 (1) Investments described in section 2, chapter 467, Oregon Laws 2021.

2 (2) Community-level interventions that include but are not limited to members and are  
 3 focused on improving the physical, mental or behavioral health of the community in which  
 4 the coordinated care organization operates and health care quality in the community.

5 (3) Enhanced payments to health care providers or to health care staff that address the  
 6 needs of the community.

7 (4) Investments in infrastructure that benefit the community as a whole.

8 (5) Financial support provided to local organizations working to enact antipoverty policies  
 9 or land use policies that create or maintain affordable housing.

10 (6) Funding for supportive or supported housing initiatives.

11 (7) Funding for new housing or for room and board.

12 (8) Funding, in collaboration with local governments or community organizations, for  
 13 community enhancements such as park improvements or bicycle lanes.

14 (9) Funding, in partnership with early learning hubs, to support parenting education or  
 15 language and literacy courses.

16 (10) Funding for educational advancement including, but not limited to, high school  
 17 mentoring programs, vocational training programs and General Educational Development  
 18 (GED) programs.

19 (11) Funding to support programs designed to address loneliness and social isolation.

20 (12) Funding programs for traditional health workers, as defined in ORS 414.665, including  
 21 programs in which traditional health workers are stationed in housing communities or other  
 22 key environments.

23 (13) Funding a medical-legal partnership to support members of a coordinated care or-  
 24 ganization with legal issues related to housing, discrimination, immigration or other legal  
 25 issues affecting members.

26 (14) Funding licenses for community-based organizations or infrastructure to enable the  
 27 organizations' use of community-based exchange platforms.

28 **SECTION 3.** (1) Each fiscal year the Oregon Health Authority shall invest not less than  
 29 three percent of the amount appropriated to the authority from the General Fund to ad-  
 30 minister the portion of the medical assistance program that serves recipients who are not  
 31 enrolled in coordinated care organizations in the previous fiscal year, on expenditures de-  
 32 scribed in section 2 of this 2022 Act.

33 (2) No later than January 1 of each calendar year, the authority shall report to the in-  
 34 terim committees of the Legislative Assembly related to health, in the manner provided in  
 35 ORS 192.245, the details of the authority's expenditures under subsection (1) of this section  
 36 for the previously completed fiscal year.

37 **SECTION 4.** The first report described in section 3 (2) of this 2022 Act is due no later  
 38 than January 1, 2024.

39 **SECTION 5.** ORS 414.572, as operative until July 1, 2022, is amended to read:

40 414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-  
 41 quirements for a coordinated care organization and shall integrate the criteria and requirements  
 42 into each contract with a coordinated care organization. Coordinated care organizations may be  
 43 local, community-based organizations or statewide organizations with community-based participation  
 44 in governance or any combination of the two. Coordinated care organizations may contract with  
 45 counties or with other public or private entities to provide services to members. The authority may

1 not contract with only one statewide organization. A coordinated care organization may be a single  
2 corporate structure or a network of providers organized through contractual relationships. The cri-  
3 teria and requirements adopted by the authority under this section must include, but are not limited  
4 to, a requirement that the coordinated care organization:

5 (a) Have demonstrated experience and a capacity for managing financial risk and establishing  
6 financial reserves.

7 (b) Meet the following minimum financial requirements:

8 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-  
9 nated care organization's total actual or projected liabilities above \$250,000.

10 (B) Maintain capital or surplus of not less than \$2,500,000 and any additional amounts necessary  
11 to ensure the solvency of the coordinated care organization, as specified by the authority by rules  
12 that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

13 (C) Expend [*a portion of the annual net income or reserves of the coordinated care organization*  
14 *that exceed the financial requirements specified in this paragraph*] **no more than three percent of**  
15 **the coordinated care organization's administrative budget** on services **prescribed by the au-**  
16 **thority by rule under section 2 of this 2022 Act that are** designed to address health disparities  
17 and the social determinants of health consistent with the coordinated care organization's community  
18 health improvement plan and transformation plan and the terms and conditions of the Medicaid  
19 demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315). **This subpar-**  
20 **agraph does not prohibit a coordinated care organization from choosing to spend more than**  
21 **three percent of the coordinated care organization's administrative budget on such services.**

22 (c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as de-  
23 fined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care  
24 organization's total expenditures for physical and mental health care provided to members, except  
25 for expenditures on prescription drugs, vision care and dental care.

26 (d) Develop and implement alternative payment methodologies that are based on health care  
27 quality and improved health outcomes.

28 (e) Coordinate the delivery of physical health care, mental health and chemical dependency  
29 services, oral health care and covered long-term care services.

30 (f) Engage community members and health care providers in improving the health of the com-  
31 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that  
32 exist among the coordinated care organization's members and in the coordinated care organization's  
33 community.

34 (2) In addition to the criteria and requirements specified in subsection (1) of this section, the  
35 authority must adopt by rule requirements for coordinated care organizations contracting with the  
36 authority so that:

37 (a) Each member of the coordinated care organization receives integrated person centered care  
38 and services designed to provide choice, independence and dignity.

39 (b) Each member has a consistent and stable relationship with a care team that is responsible  
40 for comprehensive care management and service delivery.

41 (c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,  
42 using patient centered primary care homes, behavioral health homes or other models that support  
43 patient centered primary care and behavioral health care and individualized care plans to the extent  
44 feasible.

45 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-

1 tering and leaving an acute care facility or a long term care setting.

2 (e) Members receive assistance in navigating the health care delivery system and in accessing  
 3 community and social support services and statewide resources, including through the use of certi-  
 4 fied health care interpreters and qualified health care interpreters, as those terms are defined in  
 5 ORS 413.550.

6 (f) Services and supports are geographically located as close to where members reside as possi-  
 7 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse  
 8 communities and underserved populations.

9 (g) Each coordinated care organization uses health information technology to link services and  
 10 care providers across the continuum of care to the greatest extent practicable and if financially vi-  
 11 able.

12 (h) Each coordinated care organization complies with the safeguards for members described in  
 13 ORS 414.605.

14 (i) Each coordinated care organization convenes a community advisory council that meets the  
 15 criteria specified in ORS 414.575.

16 (j) Each coordinated care organization prioritizes working with members who have high health  
 17 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those  
 18 members in accessing and managing appropriate preventive, health, remedial and supportive care  
 19 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-  
 20 gency room visits and hospital admissions.

21 (k) Members have a choice of providers within the coordinated care organization's network and  
 22 that providers participating in a coordinated care organization:

23 (A) Work together to develop best practices for care and service delivery to reduce waste and  
 24 improve the health and well-being of members.

25 (B) Are educated about the integrated approach and how to access and communicate within the  
 26 integrated system about a patient's treatment plan and health history.

27 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-  
 28 making and communication.

29 (D) Are permitted to participate in the networks of multiple coordinated care organizations.

30 (E) Include providers of specialty care.

31 (F) Are selected by coordinated care organizations using universal application and credentialing  
 32 procedures and objective quality information and are removed if the providers fail to meet objective  
 33 quality standards.

34 (G) Work together to develop best practices for culturally appropriate care and service delivery  
 35 to reduce waste, reduce health disparities and improve the health and well-being of members.

36 (L) Each coordinated care organization reports on outcome and quality measures adopted under  
 37 ORS 414.638 and participates in the health care data reporting system established in ORS 442.372  
 38 and 442.373.

39 (m) Each coordinated care organization uses best practices in the management of finances,  
 40 contracts, claims processing, payment functions and provider networks.

41 (n) Each coordinated care organization participates in the learning collaborative described in  
 42 ORS 413.259 (3).

43 (o) Each coordinated care organization has a governing body that complies with ORS 414.584  
 44 and that includes:

45 (A) At least one member representing persons that share in the financial risk of the organiza-

1 tion;

2 (B) A representative of a dental care organization selected by the coordinated care organization;

3 (C) The major components of the health care delivery system;

4 (D) At least two health care providers in active practice, including:

5 (i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS  
6 678.375, whose area of practice is primary care; and

7 (ii) A mental health or chemical dependency treatment provider;

8 (E) At least two members from the community at large, to ensure that the organization's  
9 decision-making is consistent with the values of the members and the community; and

10 (F) At least two members of the community advisory council, one of whom is or was within the  
11 previous six months a recipient of medical assistance and is at least 16 years of age, or a parent,  
12 guardian or primary caregiver of an individual who is or was within the previous six months a re-  
13 cipient of medical assistance.

14 (p) Each coordinated care organization's governing body establishes standards for publicizing  
15 the activities of the coordinated care organization and the organization's community advisory  
16 councils, as necessary, to keep the community informed.

17 (q) Each coordinated care organization publishes on a website maintained by or on behalf of the  
18 coordinated care organization, in a manner determined by the authority, a document designed to  
19 educate members about best practices, care quality expectations, screening practices, treatment  
20 options and other support resources available for members who have mental illnesses or substance  
21 use disorders.

22 (r) Each coordinated care organization works with the Tribal Advisory Council established in  
23 ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

24 (A) Facilitate a resolution of any issues that arise between the coordinated care organization  
25 and a provider of Indian health services within the area served by the coordinated care organiza-  
26 tion;

27 (B) Participate in the community health assessment and the development of the health im-  
28 provement plan;

29 (C) Communicate regularly with the Tribal Advisory Council; and

30 (D) Be available for training by the office within the authority that is responsible for tribal af-  
31 fairs, any federally recognized tribe in Oregon and the urban Indian health program that is located  
32 within the area served by the coordinated care organization and operated by an urban Indian or-  
33 ganization pursuant to 25 U.S.C. 1651.

34 (3) The authority shall consider the participation of area agencies and other nonprofit agencies  
35 in the configuration of coordinated care organizations.

36 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-  
37 thority shall:

38 (a) For members and potential members, optimize access to care and choice of providers;

39 (b) For providers, optimize choice in contracting with coordinated care organizations; and

40 (c) Allow more than one coordinated care organization to serve the geographic area if necessary  
41 to optimize access and choice under this subsection.

42 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual  
43 relationship with any dental care organization that serves members of the coordinated care organ-  
44 ization in the area where they reside.

45 **SECTION 6.** ORS 414.572 is amended to read:

1 414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-  
2 quirements for a coordinated care organization and shall integrate the criteria and requirements  
3 into each contract with a coordinated care organization. Coordinated care organizations may be  
4 local, community-based organizations or statewide organizations with community-based participation  
5 in governance or any combination of the two. Coordinated care organizations may contract with  
6 counties or with other public or private entities to provide services to members. The authority may  
7 not contract with only one statewide organization. A coordinated care organization may be a single  
8 corporate structure or a network of providers organized through contractual relationships. The cri-  
9 teria and requirements adopted by the authority under this section must include, but are not limited  
10 to, a requirement that the coordinated care organization:

11 (a) Have demonstrated experience and a capacity for managing financial risk and establishing  
12 financial reserves.

13 (b) Meet the following minimum financial requirements:

14 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-  
15 nated care organization's total actual or projected liabilities above \$250,000.

16 (B) Maintain capital or surplus of not less than \$2,500,000 and any additional amounts necessary  
17 to ensure the solvency of the coordinated care organization, as specified by the authority by rules  
18 that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

19 (C) Expend [*a portion of the annual net income or reserves of the coordinated care organization*  
20 *that exceed the financial requirements specified in this paragraph*] **no more than three percent of**  
21 **the coordinated care organization's administrative budget** on services **prescribed by the au-**  
22 **thority by rule under section 2 of this 2022 Act that are** designed to address health disparities  
23 and the social determinants of health consistent with the coordinated care organization's community  
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25 demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315). **This subpar-**  
26 **agraph does not prohibit a coordinated care organization from choosing to spend more than**  
27 **three percent of the coordinated care organization's administrative budget on such services.**

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30 organization's total expenditures for physical and mental health care provided to members, except  
31 for expenditures on prescription drugs, vision care and dental care.

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33 quality and improved health outcomes.

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35 covered long-term care services.

36 (f) Engage community members and health care providers in improving the health of the com-  
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41 authority must adopt by rule requirements for coordinated care organizations contracting with the  
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44 and services designed to provide choice, independence and dignity.

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2 (c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,  
3 using patient centered primary care homes, behavioral health homes or other models that support  
4 patient centered primary care and behavioral health care and individualized care plans to the extent  
5 feasible.

6 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-  
7 tering and leaving an acute care facility or a long term care setting.

8 (e) Members are provided:

9 (A) Assistance in navigating the health care delivery system;

10 (B) Assistance in accessing community and social support services and statewide resources;

11 (C) Meaningful language access as required by federal and state law including, but not limited  
12 to, 42 U.S.C. 18116, Title VI of the Civil Rights Act of 1964, Title VI Guidance issued by the United  
13 States Department of Justice and the National Standards for Culturally and Linguistically Appro-  
14 priate Services in Health and Health Care as issued by the United States Department of Health and  
15 Human Services; and

16 (D) Qualified health care interpreters or certified health care interpreters listed on the health  
17 care interpreter registry, as those terms are defined in ORS 413.550.

18 (f) Services and supports are geographically located as close to where members reside as possi-  
19 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse  
20 communities and underserved populations.

21 (g) Each coordinated care organization uses health information technology to link services and  
22 care providers across the continuum of care to the greatest extent practicable and if financially vi-  
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24 (h) Each coordinated care organization complies with the safeguards for members described in  
25 ORS 414.605.

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27 criteria specified in ORS 414.575.

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29 care needs, multiple chronic conditions or behavioral health conditions and involves those members  
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41 (D) Are permitted to participate in the networks of multiple coordinated care organizations.

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44 procedures and objective quality information and are removed if the providers fail to meet objective  
45 quality standards.

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 3 being of members.

4 (L) Each coordinated care organization reports on outcome and quality measures adopted under  
 5 ORS 414.638 and participates in the health care data reporting system established in ORS 442.372  
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 12 and that includes:

13 (A) At least one member representing persons that share in the financial risk of the organiza-  
 14 tion;

15 (B) A representative of a dental care organization selected by the coordinated care organization;

16 (C) The major components of the health care delivery system;

17 (D) At least two health care providers in active practice, including:

18 (i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS  
 19 678.375, whose area of practice is primary care; and

20 (ii) A behavioral health provider;

21 (E) At least two members from the community at large, to ensure that the organization's  
 22 decision-making is consistent with the values of the members and the community; and

23 (F) At least two members of the community advisory council, one of whom is or was within the  
 24 previous six months a recipient of medical assistance and is at least 16 years of age, or a parent,  
 25 guardian or primary caregiver of an individual who is or was within the previous six months a re-  
 26 cipient of medical assistance.

27 (p) Each coordinated care organization's governing body establishes standards for publicizing  
 28 the activities of the coordinated care organization and the organization's community advisory  
 29 councils, as necessary, to keep the community informed.

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40 (B) Participate in the community health assessment and the development of the health im-  
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42 (C) Communicate regularly with the Tribal Advisory Council; and

43 (D) Be available for training by the office within the authority that is responsible for tribal af-  
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 45 within the area served by the coordinated care organization and operated by an urban Indian or-

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10 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual  
11 relationship with any dental care organization that serves members of the coordinated care organ-  
12 ization in the area where they reside.

13 **SECTION 7.** ORS 414.572, as amended by section 14, chapter 489, Oregon Laws 2017, section  
14 4, chapter 49, Oregon Laws 2018, section 8, chapter 358, Oregon Laws 2019, section 2, chapter 364,  
15 Oregon Laws 2019, section 58, chapter 478, Oregon Laws 2019, section 7, chapter 529, Oregon Laws  
16 2019, and section 14, chapter 453, Oregon Laws 2021, is amended to read:

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38 **thority by rule under section 2 of this 2022 Act that are** designed to address health disparities  
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41 demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315). **This subpar-**  
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1 and mental health care provided to members, except for expenditures on prescription drugs, vision  
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29 States Department of Justice and the National Standards for Culturally and Linguistically Appro-  
30 priate Services in Health and Health Care as issued by the United States Department of Health and  
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32 (D) Qualified health care interpreters or certified health care interpreters listed on the health  
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 2 vices, including the services described in ORS 414.766, to reduce the use of avoidable emergency  
 3 room visits and hospital admissions.

4 (k) Members have a choice of providers within the coordinated care organization's network and  
 5 that providers participating in a coordinated care organization:

6 (A) Work together to develop best practices for care and service delivery to reduce waste and  
 7 improve the health and well-being of members.

8 (B) Are educated about the integrated approach and how to access and communicate within the  
 9 integrated system about a patient's treatment plan and health history.

10 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-  
 11 making and communication.

12 (D) Are permitted to participate in the networks of multiple coordinated care organizations.

13 (E) Include providers of specialty care.

14 (F) Are selected by coordinated care organizations using universal application and credentialing  
 15 procedures and objective quality information and are removed if the providers fail to meet objective  
 16 quality standards.

17 (G) Work together to develop best practices for culturally and linguistically appropriate care  
 18 and service delivery to reduce waste, reduce health disparities and improve the health and well-  
 19 being of members.

20 (L) Each coordinated care organization reports on outcome and quality measures adopted under  
 21 ORS 414.638 and participates in the health care data reporting system established in ORS 442.372  
 22 and 442.373.

23 (m) Each coordinated care organization uses best practices in the management of finances,  
 24 contracts, claims processing, payment functions and provider networks.

25 (n) Each coordinated care organization participates in the learning collaborative described in  
 26 ORS 413.259 (3).

27 (o) Each coordinated care organization has a governing body that complies with ORS 414.584  
 28 and that includes:

29 (A) At least one member representing persons that share in the financial risk of the organiza-  
 30 tion;

31 (B) A representative of a dental care organization selected by the coordinated care organization;

32 (C) The major components of the health care delivery system;

33 (D) At least two health care providers in active practice, including:

34 (i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS  
 35 678.375, whose area of practice is primary care; and

36 (ii) A behavioral health provider;

37 (E) At least two members from the community at large, to ensure that the organization's  
 38 decision-making is consistent with the values of the members and the community; and

39 (F) At least two members of the community advisory council, one of whom is or was within the  
 40 previous six months a recipient of medical assistance and is at least 16 years of age or a parent,  
 41 guardian or primary caregiver of an individual who is or was within the previous six months a re-  
 42 cipient of medical assistance.

43 (p) Each coordinated care organization's governing body establishes standards for publicizing  
 44 the activities of the coordinated care organization and the organization's community advisory  
 45 councils, as necessary, to keep the community informed.

1 (q) Each coordinated care organization publishes on a website maintained by or on behalf of the  
 2 coordinated care organization, in a manner determined by the authority, a document designed to  
 3 educate members about best practices, care quality expectations, screening practices, treatment  
 4 options and other support resources available for members who have mental illnesses or substance  
 5 use disorders.

6 (r) Each coordinated care organization works with the Tribal Advisory Council established in  
 7 ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

8 (A) Facilitate a resolution of any issues that arise between the coordinated care organization  
 9 and a provider of Indian health services within the area served by the coordinated care organiza-  
 10 tion;

11 (B) Participate in the community health assessment and the development of the health im-  
 12 provement plan;

13 (C) Communicate regularly with the Tribal Advisory Council; and

14 (D) Be available for training by the office within the authority that is responsible for tribal af-  
 15 fairs, any federally recognized tribe in Oregon and the urban Indian health program that is located  
 16 within the area served by the coordinated care organization and operated by an urban Indian or-  
 17 ganization pursuant to 25 U.S.C. 1651.

18 (3) The authority shall consider the participation of area agencies and other nonprofit agencies  
 19 in the configuration of coordinated care organizations.

20 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-  
 21 thority shall:

22 (a) For members and potential members, optimize access to care and choice of providers;

23 (b) For providers, optimize choice in contracting with coordinated care organizations; and

24 (c) Allow more than one coordinated care organization to serve the geographic area if necessary  
 25 to optimize access and choice under this subsection.

26 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual  
 27 relationship with any dental care organization that serves members of the coordinated care organ-  
 28 ization in the area where they reside.

29 **SECTION 8.** ORS 415.011 is amended to read:

30 415.011. (1) The Oregon Health Authority may adopt rules to carry out the provisions of ORS  
 31 415.012 to 415.430.

32 (2) The authority shall adopt rules for regulating the financial solvency of coordinated care or-  
 33 ganizations that align with the following provisions of the Insurance Code regulating domestic  
 34 insurers, to the extent the provisions regarding insurers are applicable to coordinated care organ-  
 35 izations and are in accordance with ORS chapters 413 and 414:

36 (a) ORS 731.385;

37 (b) ORS 731.504;

38 (c) ORS 731.508;

39 (d) ORS 731.509 (1) to (10) and (12);

40 (e) ORS 731.574 (1) to (5);

41 (f) ORS 731.730;

42 (g) ORS 731.988;

43 (h) ORS 732.235;

44 (i) ORS 732.517 to 732.546, other than ORS 732.527, 732.531 and 732.541;

45 (j) ORS 732.548;

- 1 (k) ORS 732.549;
- 2 (L) ORS 732.551;
- 3 (m) ORS 732.552;
- 4 (n) ORS 732.553;
- 5 (o) ORS 732.554;
- 6 (p) ORS 732.556;
- 7 (q) ORS 732.558;
- 8 (r) ORS 732.564;
- 9 (s) ORS 732.566;
- 10 (t) ORS 732.567;
- 11 (u) ORS 732.568;
- 12 (v) ORS 732.569;
- 13 (w) ORS 732.574;
- 14 (x) ORS 732.576;
- 15 (y) ORS 732.578;
- 16 (z) ORS 732.592;
- 17 (aa) ORS 733.010 to 733.050;
- 18 (bb) ORS 733.140 to 733.170;
- 19 (cc) ORS 733.510 to 733.680;
- 20 (dd) ORS 733.695 to 733.780; and
- 21 (ee) ORS 734.014.

22 (3) Rules adopted by the authority in accordance with ORS 731.385 that establish minimum  
23 standards for risk-based capital may not require a coordinated care organization to take preventive  
24 or corrective measures to increase the coordinated care organization’s capital, surplus or reserves  
25 to achieve more than 200 percent of the minimum risk-based capital. **The authority may not adopt**  
26 **rules restricting distributions or other expenditures that exceed 200 percent of the minimum**  
27 **risk-based capital.**

28 **SECTION 9. This 2022 Act being necessary for the immediate preservation of the public**  
29 **peace, health and safety, an emergency is declared to exist, and this 2022 Act takes effect**  
30 **on its passage.**

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