A-Engrossed
Senate Bill 1508

Ordered by the Senate February 9
Including Senate Amendments dated February 9

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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. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act forbids the HERC from using quality of life to measure the weight to give to a service that may be covered by the state Medicaid program.

The Act caps the amount a person must pay for insulin under a health benefit plan to $35. (Flesch Readability Score: 63.9).

[*Digest: The Act forbids the HERC from using quality of life to measure the weight to give to a service that may be covered by the state Medicaid program. (Flesch Readability Score: 63.6).*]

In determining the ranking of a condition-treatment pair on the prioritized list of health services covered by the medical assistance program, prohibits the Health Evidence Review Commission from relying upon a quality of life in general measure or from relying on any research or analyses that rely upon or refer to a quality of life measure, unless specified conditions are met.

Caps cost-sharing required by health benefit plans at $35 for coverage of insulin.

1 **A BILL FOR AN ACT**

2 Relating to health care; creating new provisions; and amending ORS 414.025, 414.065, 414.689,
3 414.690, 414.701 and 743A.069.
4 **Be It Enacted by the People of the State of Oregon:**
5
6 **QUALITY OF LIFE MEASURES**
7
8 **SECTION 1.** ORS 414.065 is amended to read:
9 414.065. (1)(a) [*With respect to health care and services to be provided in medical assistance during*
10 *any period, the Oregon Health Authority shall determine,*] **Consistent with ORS 414.690, 414.710,**
11 **414.712 and 414.766 and other statutes governing the provision of and payments for health**
12 **services in medical assistance, the Oregon Health Authority shall determine,** subject to such
13 revisions as it may make from time to time and [*subject*] to legislative funding [*and paragraph (b)*
14 *of this subsection*]:
15 (A) The types and extent of health [*care and*] services to be provided to each eligible group of
16 recipients of medical assistance.
17 (B) Standards, including outcome and quality measures, to be observed in the provision of health
18 [*care and*] services.
19 (C) The number of days of health [*care and*] services toward the cost of which medical assistance
20 funds will be expended in the care of any person.
21 (D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing
22 health services to an applicant or recipient.

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.

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(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(F) The amount and application of any copayment or other similar cost-sharing payment that the authority may require a recipient to pay toward the cost of health [*care or*] services.

(b) The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

(2) In making the determinations under subsection (1) of this section and in the imposition of any utilization controls on access to health services, the authority may not consider a quality of life in general measure, either directly or by considering a source that relies on a quality of life in general measure.

[*(2)*] **(3)** The types and extent of health [*care and*] services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the authority and within the limits of funds available therefor, shall be the total available for medical assistance**,** and payments for such medical assistance shall be the total amounts from medical assistance funds available to providers of health [*care and*] services in meeting the costs thereof.

[*(3)*] **(4)** Except for payments under a cost-sharing plan, payments made by the authority for medical assistance shall constitute payment in full for all health [*care and*] services for which such payments of medical assistance were made.

[*(4)*] **(5)** Notwithstanding [*subsections (1) and (2)*] **subsection (1)** of this section, the Department of Human Services shall be responsible for determining the payment for Medicaid-funded long term care services and for contracting with the providers of long term care services.

[*(5)*] **(6)** In determining a global budget for a coordinated care organization:

(a) The allocation of the payment, the risk and any cost savings shall be determined by the governing body of the organization;

(b) The authority shall consider the community health assessment conducted by the organization in accordance with ORS 414.577 and reviewed annually, and the organization's health care costs; and

(c) The authority shall take into account the organization's provision of innovative, nontraditional health services.

[*(6)*] **(7)** Under the supervision of the Governor, the authority may work with the Centers for Medicare and Medicaid Services to develop, in addition to global budgets, payment streams:

(a) To support improved delivery of health care to recipients of medical assistance; and

(b) That are funded by coordinated care organizations, counties or other entities other than the state whose contributions qualify for federal matching funds under Title XIX or XXI of the Social Security Act.

SECTION 2. ORS 414.689 is amended to read:

414.689. (1) The Health Evidence Review Commission shall select one of its members as chairperson and another as vice chairperson, for terms and with duties and powers the commission determines necessary for the performance of the functions of the offices.

(2) A majority of the members of the commission constitutes a quorum for the transaction of business.

(3) The commission shall meet at least four times per year at a place, day and hour determined by the chairperson. The commission also shall meet at other times and places specified by the call of the chairperson or of a majority of the members of the commission. **All meetings and deliberations of the commission shall be in accordance with ORS 192.610 to 192.690. The commission**

1 **may not meet in executive session to hear evidence from an advisory committee or sub-**
2 **committee or a panel of experts or to deliberate on matters presented by an advisory com-**
3 **mittee or subcommittee or a panel of experts.**
4 (4) The commission may use advisory committees or subcommittees whose members are ap-
5 pointed by the chairperson of the commission subject to approval by a majority of the members of
6 the commission. The advisory committees or subcommittees may contain experts appointed by the
7 chairperson and a majority of the members of the commission. The conditions of service of the ex-
8 perts will be determined by the chairperson and a majority of the members of the commission.
9 (5) The Oregon Health Authority shall provide staff and support services to the commission.
10 **SECTION 3.** ORS 414.690 is amended to read:
11 414.690. (1) The Health Evidence Review Commission shall regularly solicit testimony and in-
12 formation from stakeholders representing consumers, advocates, providers, carriers and employers
13 in conducting the work of the commission.
14 (2) The commission shall actively solicit public involvement through a public meeting process
15 to guide health resource allocation decisions **that includes, but is not limited to:**
16 **(a) Providing members of the public the opportunity to provide input on the selection of**
17 **any vendor that provides research and analysis to the commission; and**
18 **(b) Inviting public comment on any research or analysis tool or health economic meas-**
19 **ures to be relied upon by the commission in the commission's decision-making**.
20 (3)**(a)** The commission shall develop and maintain a list of health services ranked by priority,
21 from the most important to the least important, representing the comparative benefits of each ser-
22 vice to the population to be served.
23 **(b) Except as provided in ORS 414.701, the commission may not rely upon any quality of**
24 **life in general measures, either directly or by considering research or analysis that relies on**
25 **a quality of life in general measure, in determining:**
26 **(A) Whether a service is cost-effective;**
27 **(B) Whether a service is recommended; or**
28 **(C) The value of a service.**
29 **(c)** The list must be submitted by the commission pursuant to subsection (5) of this section and
30 is not subject to alteration by any other state agency.
31 (4) In order to encourage effective and efficient medical evaluation and treatment, the commis-
32 sion:
33 (a) May include clinical practice guidelines in its prioritized list of services. The commission
34 shall actively solicit testimony and information from the medical community and the public to build
35 a consensus on clinical practice guidelines developed by the commission.
36 (b) May include statements of intent in its prioritized list of services. Statements of intent should
37 give direction on coverage decisions where medical codes and clinical practice guidelines cannot
38 convey the intent of the commission.
39 (c) Shall consider both the clinical effectiveness and cost-effectiveness of health services, in-
40 cluding drug therapies, in determining their relative importance using peer-reviewed medical litera-
41 ture [*as defined in ORS 743A.060*].
42 (5) The commission shall report the prioritized list of services to the Oregon Health Authority
43 for budget determinations by July 1 of each even-numbered year.
44 (6) The commission shall make its report during each regular session of the Legislative Assem-
45 bly and shall submit a copy of its report to the Governor, the Speaker of the House of Represen-

1 tatives and the President of the Senate **and post to the Oregon Health Authority's website,**
2 **along with a solicitation of public comment, an assessment of the impact on access to med-**
3 **ically necessary treatment and services by persons with disabilities or chronic illnesses re-**
4 **sulting from the commission's prior use of any quality of life in general measures or any**
5 **research or analysis that referred to or relied upon a quality of life in general measure**.
6 (7) The commission may alter the list during the interim only as follows:
7 (a) To make technical changes to correct errors and omissions;
8 (b) To accommodate changes due to advancements in medical technology or new data regarding
9 health outcomes;
10 (c) To accommodate changes to clinical practice guidelines; and
11 (d) To add statements of intent that clarify the prioritized list.
12 (8) If a service is deleted or added during an interim and no new funding is required, the com-
13 mission shall report to the Speaker of the House of Representatives and the President of the Senate.
14 However, if a service to be added requires increased funding to avoid discontinuing another service,
15 the commission shall report to the Emergency Board to request the funding.
16 (9) The prioritized list of services remains in effect for a two-year period beginning no earlier
17 than October 1 of each odd-numbered year.
18 **(10)(a) As used in this section, "peer-reviewed medical literature" means scientific**
19 **studies printed in journals or other publications that publish original manuscripts only after**
20 **the manuscripts have been critically reviewed by unbiased independent experts for scientific**
21 **accuracy, validity and reliability.**
22 **(b) "Peer-reviewed medical literature" does not include internal publications of pharma-**
23 **ceutical manufacturers.**
24 **SECTION 4.** ORS 414.701 is amended to read:
25 414.701. **(1) As used in this section, "peer-reviewed medical literature" has the meaning**
26 **given that term in ORS 414.690.**
27 **(2)** The Health Evidence Review Commission, in ranking health services or developing guide-
28 lines under ORS 414.690 or in assessing medical technologies under ORS 414.698, and the Pharmacy
29 and Therapeutics Committee, in considering a recommendation for a drug to be included on any
30 preferred drug list or on the Practitioner-Managed Prescription Drug Plan[,]**:**
31 **(a)** May not rely solely on the results of comparative effectiveness research **but must evaluate**
32 **a range of research and analysis, including peer-reviewed medical literature that:**
33 **(A) Studies health outcomes that are priorities for persons with disabilities who experi-**
34 **ence specific diseases or illnesses, through surveys or other methods of identifying priority**
35 **outcomes for individuals who experience the diseases or illnesses;**
36 **(B) Studies subgroups of patients who experience specific diseases or illnesses, to ensure**
37 **consideration of any important differences and clinical characteristics applicable to the sub-**
38 **groups; and**
39 **(C) Considers the full range of relevant, peer-reviewed medical literature and avoids**
40 **harm to patients caused by undue emphasis on evidence that is deemed inconclusive of clin-**
41 **ical differences without further investigation**.
42 **(b) May consider research or analyses that reference a quality of life in general measure**
43 **only if:**
44 **(A) The staff of the commission includes an individual who:**
45 **(i) Is trained in identifying bias and discrimination in medical research and analyses;**

(ii) Is not involved in research evaluation and recommendations for a given condition-treatment pair on the prioritized list subject to the commission's review; and

(iii) Determines that any of a researcher's conclusions and analyses about the value or cost-effectiveness of a treatment, that were relied upon by the staff of the commission in making a recommendation regarding the treatment, did not rely upon and were not influenced by the quality of life in general measure; and

(B) All references to the quality of life in general measure are redacted from the research or analyses before the research or analyses are presented to the commission or to any advisory committee or subcommittees used or consulted by the commission.

(3) The commission may not contract with a single vendor to provide or compile research and analysis that is considered by the commission, and the commission shall publicly disclose, regarding vendors providing or compiling research or analysis to the commission:

(a) The vendors' funding sources; and

(b) Any conflicts of interest that a vendor may have with respect to the research and analysis provided.

SECTION 5. ORS 414.025 is amended to read:

414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially applicable statutory definition requires otherwise:

(1)(a) "Alternative payment methodology" means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services.

(b) "Alternative payment methodology" includes, but is not limited to:

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

(2) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

(3) "Behavioral health clinician" means:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

(c) A licensed nurse practitioner with a specialty in psychiatric mental health;

(d) A licensed clinical social worker;

(e) A licensed professional counselor or licensed marriage and family therapist;

(f) A certified clinical social work associate;

(g) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

(h) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

(4) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

(5) "Behavioral health home" means a mental health disorder or substance use disorder treatment organization, as defined by the Oregon Health Authority by rule, that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use

disorders.

(6) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security Income payments.

(7) "Community health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services such as first aid or blood pressure screening.

(8) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.572.

(9) "Dually eligible for Medicare and Medicaid" means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

(a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or

(b) Enrolled in Part B of Title XVIII of the Social Security Act.

(10)(a) "Family support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides supportive services to and has experience parenting a child who:

(A) Is a current or former consumer of mental health or addiction treatment; or

(B) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "family support specialist" may be a peer wellness specialist or a peer support specialist.

(11) "Global budget" means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

(12) "Health insurance exchange" or "exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(13) "Health services" means at least so much of each of the following as are funded by the Legislative Assembly based upon the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690:

(a) Services required by federal law to be included in the state's medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner licensed under ORS 678.375, a behavioral health clinician or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;
(d) Laboratory and X-ray services;
(e) Medical equipment and supplies;
(f) Mental health services;
(g) Chemical dependency services;
(h) Emergency dental services;
(i) Nonemergency dental services;
(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state's medical assistance program;
(k) Emergency hospital services;
(L) Outpatient hospital services; and
(m) Inpatient hospital services.
(14) "Income" has the meaning given that term in ORS 411.704.
(15)(a) "Integrated health care" means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:
(A) Mental illness.
(B) Substance use disorders.
(C) Health behaviors that contribute to chronic illness.
(D) Life stressors and crises.
(E) Developmental risks and conditions.
(F) Stress-related physical symptoms.
(G) Preventive care.
(H) Ineffective patterns of health care utilization.
(b) As used in this subsection, "other care team members" includes but is not limited to:
(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;
(B) Peer wellness specialists;
(C) Peer support specialists;
(D) Community health workers who have completed a state-certified training program;
(E) Personal health navigators; or
(F) Other qualified individuals approved by the Oregon Health Authority.
(16) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the department or the authority may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.
(17) "Medical assistance" means so much of the medical, mental health, preventive, supportive, palliative and remedial care and services as may be prescribed by the authority according to the standards established pursuant to ORS 414.065, including premium assistance under ORS 414.115 and 414.117, payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of health services and for services described in ORS 414.710.
(18) "Medical assistance" includes any care or services for any individual who is a patient in

a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. Except as provided in ORS 411.439 and 411.447, "medical assistance" does not include care or services for a resident of a nonmedical public institution.

(19) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS 414.655 and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

(20) "Peer support specialist" means any of the following individuals who meet qualification criteria adopted by the authority under ORS 414.665 and who provide supportive services to a current or former consumer of mental health or addiction treatment:

(a) An individual who is a current or former consumer of mental health treatment; or

(b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from an addiction disorder.

(21) "Peer wellness specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

(22) "Person centered care" means care that:

(a) Reflects the individual patient's strengths and preferences;

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

(c) Is based upon the patient's goals and will assist the patient in achieving the goals.

(23) "Personal health navigator" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

(24) "Prepaid managed care health services organization" means a managed dental care, mental health or chemical dependency organization that contracts with the authority under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.

(25) "Quality measure" means the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 413.022 and the quality metrics developed by the Behavioral Health Committee in accordance with ORS 413.017 (5).

(26)(a) "Quality of life in general measure" means an assessment of the value, effective-

ness or cost-effectiveness of a treatment that gives greater value to a year of life lived in perfect health than the value given to a year of life lived in less than perfect health.

(b) "Quality of life in general measure" does not mean an assessment of the value, effectiveness or cost-effectiveness of a treatment during a clinical trial in which a study participant is asked to rate the participant's physical function, pain, general health, vitality, social functions or other similar domains.

[*(26)*] **(27)** "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

[*(27)*] **(28)** "Social determinants of health" means:

(a) Nonmedical factors that influence health outcomes;

(b) The conditions in which individuals are born, grow, work, live and age; and

(c) The forces and systems that shape the conditions of daily life, such as economic policies and systems, development agendas, social norms, social policies, racism, climate change and political systems.

[*(28)*] **(29)** "Tribal traditional health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in a tribal community or an urban Indian community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community the worker serves;

(d) Assists members of the community to improve their health, including physical, behavioral and oral health, and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services, such as tribal-based practices.

[*(29)(a)*] **(30)(a)** "Youth support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

(A) Is not older than 30 years of age; and

(B)(i) Is a current or former consumer of mental health or addiction treatment; or

(ii) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "youth support specialist" may be a peer wellness specialist or a peer support specialist.

SECTION 6. ORS 414.025, as amended by section 2, chapter 628, Oregon Laws 2021, is amended to read:

414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially applicable statutory definition requires otherwise:

(1)(a) "Alternative payment methodology" means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services.

(b) "Alternative payment methodology" includes, but is not limited to:
(A) Shared savings arrangements;
(B) Bundled payments; and
(C) Payments based on episodes.
(2) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.
(3) "Behavioral health clinician" means:
(a) A licensed psychiatrist;
(b) A licensed psychologist;
(c) A licensed nurse practitioner with a specialty in psychiatric mental health;
(d) A licensed clinical social worker;
(e) A licensed professional counselor or licensed marriage and family therapist;
(f) A certified clinical social work associate;
(g) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or
(h) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.
(4) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.
(5) "Behavioral health home" means a mental health disorder or substance use disorder treatment organization, as defined by the Oregon Health Authority by rule, that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders.
(6) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security Income payments.
(7) "Community health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:
(a) Has expertise or experience in public health;
(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;
(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community the worker serves;
(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;
(e) Provides health education and information that is culturally appropriate to the individuals being served;
(f) Assists community residents in receiving the care they need;
(g) May give peer counseling and guidance on health behaviors; and
(h) May provide direct services such as first aid or blood pressure screening.
(8) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.572.
(9) "Dually eligible for Medicare and Medicaid" means, with respect to eligibility for enrollment

in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

(a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or

(b) Enrolled in Part B of Title XVIII of the Social Security Act.

(10)(a) "Family support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides supportive services to and has experience parenting a child who:

(A) Is a current or former consumer of mental health or addiction treatment; or

(B) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "family support specialist" may be a peer wellness specialist or a peer support specialist.

(11) "Global budget" means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

(12) "Health insurance exchange" or "exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(13) "Health services" means at least so much of each of the following as are funded by the Legislative Assembly based upon the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690:

(a) Services required by federal law to be included in the state's medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner licensed under ORS 678.375, a behavioral health clinician or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state's medical assistance program;

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

(14) "Income" has the meaning given that term in ORS 411.704.

(15)(a) "Integrated health care" means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:

(A) Mental illness.

(B) Substance use disorders.

(C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.
(E) Developmental risks and conditions.
(F) Stress-related physical symptoms.
(G) Preventive care.
(H) Ineffective patterns of health care utilization.
(b) As used in this subsection, "other care team members" includes but is not limited to:
(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;
(B) Peer wellness specialists;
(C) Peer support specialists;
(D) Community health workers who have completed a state-certified training program;
(E) Personal health navigators; or
(F) Other qualified individuals approved by the Oregon Health Authority.
(16) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the department or the authority may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.
(17) "Medical assistance" means so much of the medical, mental health, preventive, supportive, palliative and remedial care and services as may be prescribed by the authority according to the standards established pursuant to ORS 414.065, including premium assistance under ORS 414.115 and 414.117, payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of health services and for services described in ORS 414.710.
(18) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. Except as provided in ORS 411.439 and 411.447, "medical assistance" does not include care or services for a resident of a nonmedical public institution.
(19) "Mental health drug" means a type of legend drug, as defined in ORS 414.325, specified by the Oregon Health Authority by rule, including but not limited to:
(a) Therapeutic class 7 ataractics-tranquilizers; and
(b) Therapeutic class 11 psychostimulants-antidepressants.
(20) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS 414.655 and that incorporates the following core attributes:
(a) Access to care;
(b) Accountability to consumers and to the community;
(c) Comprehensive whole person care;
(d) Continuity of care;
(e) Coordination and integration of care; and
(f) Person and family centered care.
(21) "Peer support specialist" means any of the following individuals who meet qualification criteria adopted by the authority under ORS 414.665 and who provide supportive services to a current or former consumer of mental health or addiction treatment:
(a) An individual who is a current or former consumer of mental health treatment; or

(b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from an addiction disorder.

(22) "Peer wellness specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

(23) "Person centered care" means care that:

(a) Reflects the individual patient's strengths and preferences;

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

(c) Is based upon the patient's goals and will assist the patient in achieving the goals.

(24) "Personal health navigator" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

(25) "Prepaid managed care health services organization" means a managed dental care, mental health or chemical dependency organization that contracts with the authority under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.

(26) "Quality measure" means the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 413.022 and the quality metrics developed by the Behavioral Health Committee in accordance with ORS 413.017 (5).

(27)(a) "Quality of life in general measure" means an assessment of the value, effectiveness or cost-effectiveness of a treatment that gives greater value to a year of life lived in perfect health than the value given to a year of life lived in less than perfect health.

(b) "Quality of life in general measure" does not mean an assessment of the value, effectiveness or cost-effectiveness of a treatment during a clinical trial in which a study participant is asked to rate the participant's physical function, pain, general health, vitality, social functions or other similar domains.

[*(27)*] **(28)** "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

[*(28)*] **(29)** "Social determinants of health" means:

(a) Nonmedical factors that influence health outcomes;

(b) The conditions in which individuals are born, grow, work, live and age; and

(c) The forces and systems that shape the conditions of daily life, such as economic policies and systems, development agendas, social norms, social policies, racism, climate change and political systems.

[*(29)*] **(30)** "Tribal traditional health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in a tribal community or an urban Indian community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community the worker serves;

(d) Assists members of the community to improve their health, including physical, behavioral and oral health, and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services, such as tribal-based practices.

[*(30)(a)*] **(31)(a)** "Youth support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

(A) Is not older than 30 years of age; and

(B)(i) Is a current or former consumer of mental health or addiction treatment; or

(ii) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A "youth support specialist" may be a peer wellness specialist or a peer support specialist.

HEALTH INSURANCE COVERAGE OF INSULIN

SECTION 7. ORS 743A.069 is amended to read:

743A.069. (1) As used in this section:

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

(b) "Insulin" has the meaning given that term in ORS 689.696.

(2) A health benefit plan offered in this state may not require an enrollee in the plan to incur cost-sharing or other out-of-pocket costs[*, as adjusted under subsection (3) of this section,*] that exceed [*$75*] **$35** for each 30-day supply of a type of insulin prescribed for the treatment of diabetes or [*$225*] **$105** for each 90-day supply.

[*(3) The Department of Consumer and Business Services shall, by rule, annually adjust the maximum cost specified in subsection (2) of this section by the percentage increase, if any, in the cost of living for the previous calendar year, based on changes in the Consumer Price Index for All Urban Consumers, West Region (All Items), as published by the Bureau of Labor Statistics of the United States Department of Labor.*]

[*(4)*] **(3)** The coverage under this section may not be subject to a deductible imposed by a health benefit plan.

[*(5)*] **(4)** This section does not prohibit a health benefit plan from using a drug formulary or other utilization review protocol applicable to prescription drug coverage under the plan.

[*(6)*] **(5)** This section is not subject to ORS 743A.001.

SECTION 8. The amendments to ORS 743A.069 by section 7 of this 2024 Act apply to health benefit plans issued, renewed or extended on or after the effective date of this 2024 Act.

1 **CAPTIONS**

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3 **SECTION 9.** **The unit captions used in this 2024 Act are provided only for the convenience**
4 **of the reader and do not become part of the statutory law of this state or express any leg-**
5 **islative intent in the enactment of this 2024 Act.**

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