House Bill 2148

Sponsored by Representative NOSSE (Presession 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.** The statement includes a measure digest written in compliance with applicable readability standards.

Digest: Tells OHA, CCOs and health care providers to establish certain rates for services. Makes certain provider actions an unlawful practice of law. Requires health insurers, OEBB and PEBB to spend a certain amount on primary care. Tells DCBS to set penalties. Tells OHA to make a program to expand primary care for certain services and creates a program to give money to certain primary care providers. (Flesch Readability Score: 60.1).

Requires the Oregon Health Authority to establish a fee-for-service rate for all medical assistance recipients at a certain rate for certain services.

Requires health care providers to establish reimbursement rates for all services at a certain rate. Designates a violation of reimbursement rates and balance billing requirements as an unlawful practice of law. Requires health benefit plans, health care service contractors, the Public Employees' Benefits Board and the Oregon Educators Benefits Board to spend a certain amount on primary care payments. Requires the Department of Consumer and Business Services to establish penalties for insurers not meeting the primary care payment targets.

Directs the Oregon Health Authority to establish a primary care expansion program to eligible health care clinics for specified purposes. Creates within the authority a primary care provider incentive program to provide financial incentives to eligible primary care providers. Defines "primary care provider."

A BILL FOR AN ACT

Relating to health care costs; creating new provisions; and amending ORS 243.135, 243.866, 646.608, 743.010 and 743B.287.

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

SECTION 1. Section 2 of this 2025 Act is added to and made a part of ORS chapter 414.

SECTION 2. (1) Except as provided in subsection (2) of this section, the Oregon Health Authority shall establish fee-for-service reimbursement rates for all services provided to medical assistance recipients at the same rate paid by Medicare on the date of the service.

(2) The authority shall establish fee-for-service reimbursement rates for primary care services, as defined by the authority by rule, provided to medical assistance recipients at a rate that is 130 percent of the rate paid by Medicare on the date of the service.

(3) A coordinated care organization shall reimburse providers for services provided to medical assistance recipients at the rates established by the authority under subsections (1) and (2) of this section.

SECTION 3. ORS 743B.287 is amended to read:

743B.287. (1) As used in this section:

(a) "Emergency services" has the meaning given that term in ORS 743A.012.

(b) "Enrollee" means:

(A) An individual who is enrolled in a health benefit plan or a covered dependent or beneficiary of the individual; or

(B) A subscriber to a health care service contract or a covered dependent or beneficiary of the subscriber.

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.

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

(d) "Health care facility" has the meaning given that term in ORS 442.015, excluding long term care facilities.

(e) "Health care service contractor" has the meaning given that term in ORS 750.005.

(f) "In-network" has the meaning given that term in ORS 743B.280.

(g) "Out-of-network" means a provider or provider group that has not contracted or has indirectly contracted with the insurer or health care service contractor.

(2) A provider who is an out-of-network provider may not bill an enrollee in the health benefit plan or health care service contract for emergency services or other inpatient or outpatient services provided at an in-network health care facility.

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

(a) To applicable coinsurance, copayments or deductible amounts that apply to services provided by an in-network provider; or

(b) To services, other than emergency services, provided to enrollees who choose to receive services from an out-of-network provider.

(4)(a) If labor and delivery services are provided to an individual insured under a health benefit plan or a health care service contract at an out-of-network health care facility due solely to the diversion of the individual from an in-network health care facility during a state or federally declared public health emergency, the health benefit plan or health care service contract:

(A)(i) Shall reimburse the out-of-network provider in accordance with 42 U.S.C. 300gg-111(c) or in accordance with a method adopted by the Department of Consumer and Business Services by rule; and

(ii) May not impose a deductible, out-of-pocket maximum, copayment or coinsurance requirement that exceeds the deductible, out-of-pocket maximum, copayment or coinsurance applicable to in-network providers of labor and delivery services.

(B) Shall provide coverage, as prescribed in ORS 743A.012 (2) and (3), for emergency medical services transports of the individual between medical facilities if the individual presents with signs of labor.

(b) Paragraph (a)(A)(i) of this subsection does not apply to services provided by an in-network provider at an out-of-network health care facility.

(5) If an enrollee chooses to receive services from an out-of-network provider, the provider shall inform the enrollee that the enrollee will be financially responsible for coinsurance, copayments or other out-of-pocket expenses attributable to choosing an out-of-network provider.

(6) A provider may not submit a claim for reimbursement for services at an amount greater than 150 percent of the amount Medicare reimburses for the same service.

(7) Violation of this section is an unlawful practice under ORS 646.608.

SECTION 4. ORS 743.010 is amended to read:

743.010. (1) In addition to all other powers of the Director of the Department of Consumer and Business Services with respect thereto, the director may issue rules with respect to policy forms and health benefit plan forms described in ORS 742.005 (6)(a) and (b) **and health care service contracts as described in ORS 750.095**:

(a) Establishing minimum benefit standards;

(b) Requiring the ratio of benefits to premiums to be not less than a specified percentage in order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the insurer's compliance;

(c) Establishing requirements intended to discourage duplication or overlapping of coverage and replacement, without regard to the advantage to policyholders, of existing policies by new policies; and

(d) Establishing requirements for carriers offering health benefit plans **or policies issued by health care service contractors** to spend at least 12 percent of total medical expenditures on payments for primary care **and establishing penalties for failure to meet the 12 percent spending requirement**.

(2) As used in this section:

(a) "Primary care" means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

(b) "Total medical expenditures" means payments to reimburse the cost of physical and mental health care provided to enrollees, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.

SECTION 5. ORS 243.135 is amended to read:

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

(a) Employee choice among high quality plans;

(b) A competitive marketplace;

(c) Plan performance and information;

(d) Employer flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

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

(h) The improvement of employee health; and

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

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

(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members. The board shall impose a surcharge in an amount determined by the board on an eligible employee who arranges coverage for the employee's spouse or dependent under this subsection if the spouse or dependent has access to medical coverage as an employee in another health benefit plan offered by the board or the Oregon Educators Benefit Board.

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

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

(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and their family members under rules adopted by the board. Because of the special problems that may

arise in individual instances under comprehensive group practice plan coverage involving acceptable provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

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

(8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by the board that are designed to limit the growth in per-member expenditures for health services to no more than 3.4 percent per year. The assessment paid in accordance with section 3, chapter 538, Oregon Laws 2017, shall be excluded in determining the 3.4 percent annual increase in per-member expenditures for health services.

(b) The board shall adopt policies and practices designed to limit the annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.

(9) As frequently as is recommended as a commercial best practice by consultants engaged by the board, the board shall conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.

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

(10) The board shall spend 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care.

(11) No later than February 1 of each year, the board shall report to the Legislative Assembly on [*any plan implemented under*] **the percentage of total medical expenditures spent on payments for primary care pursuant to** subsection (10) of this section [*and on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care*].

SECTION 6. ORS 243.866 is amended to read:

243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed to meet the needs and provide for the welfare of eligible employees, the districts and local governments. In considering whether to enter into a contract for a benefit plan, the board shall place emphasis on:

(a) Employee choice among high-quality plans;

(b) Encouragement of a competitive marketplace;

(c) Plan performance and information;

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

(e) Quality customer service;

(f) Creativity and innovation;

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

(h) Improvement of employee health; and

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

(2) The board may approve more than one carrier for each type of benefit plan offered, but the

board shall limit the number of carriers to a number consistent with adequate service to eligible employees and family members. The board shall impose a surcharge in an amount determined by the board on an eligible employee who arranges coverage for the employee's spouse or dependent under this subsection if the spouse or dependent has access to medical coverage as an employee in another health benefit plan offered by the board or the Public Employees' Benefit Board.

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

(4) A district or a local government shall provide that payroll deductions for benefit plan costs that are not payable by the district or local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the benefit plan or plans selected and allowing the deduction of those costs from the employee's pay.

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

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

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

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

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

(b) The board shall adopt policies and practices designed to limit the annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.

(10) As frequently as is recommended as a commercial best practice by consultants engaged by the board, the board shall conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.

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

(11) The board shall spend 12 percent of its total medical expenditures on payments for primary care.

(12) No later than February 1 of each year, the board shall report to the Legislative Assembly on [*any plan implemented under*] **the percentage of total medical expenditures spent on payments for primary care pursuant to** subsection (11) of this section[*and on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures on payments for primary care*].

SECTION 7. (1) The Oregon Health Authority shall establish a primary care expansion

program to award grants in order to increase the primary care capacity in this state. The program must award grants to eligible health care clinics for the purposes of funding capital expansion projects at the health care clinics and creating and expanding primary care provider residency programs at the health care clinics.

(2) The authority shall adopt rules to establish health care clinic eligibility criteria for grants awarded under subsection (1) of this section. The rules must include at least the following criteria:

(a) A health care clinic must be:

(A) A nonprofit county health clinic, a federally qualified health center or a rural health center; or

(B) Owned and operated by a physician licensed under ORS chapter 677, physician associate licensed under ORS 677.505 to 677.525 or nurse practitioner licensed under ORS 678.375 to 678.390.

(b) A health care clinic may not be:

(A) Operated or owned by or affiliated with a management services organization; or

(B) A for-profit hospital or affiliated with a for-profit hospital.

(3) The authority may receive gifts, grants or other contributions from any source, whether public or private, to carry out the provisions of this section. Moneys received under this section shall be deposited in the Primary Care Expansion Fund established under section 9 of this 2025 Act.

(4) As used in this section:

(a)(A) "Management services organization" means an entity that, under a written agreement and in return for compensation, provides any or all of the following management services to or on behalf of a professional corporation:

(i) Payroll.

(ii) Human resources.

(iii) Employment screening.

(iv) Employee relations.

(v) Any other administrative or business services that do not constitute the practice of medicine.

(B) "Management services organization" does not include a hospital, as defined in ORS 442.015, or a hospital-affiliated entity that provides outpatient health services and that is owned, operated or controlled by, or is under common ownership, operation or control with, a hospital. "Control" as used in this subparagraph has the meaning given that term in ORS 732.548.

(b) "Primary care provider" means a physician licensed under ORS chapter 677, a physician associate licensed under ORS 677.505 to 677.525 or a nurse practitioner licensed under ORS 678.375 to 678.390 who practices in primary care, general family medicine or pediatrics.

SECTION 8. (1) As used in this section, "management services organization" and "primary care provider" have the meanings given those terms in section 7 of this 2025 Act.

(2) There is created within the Oregon Health Authority a primary care provider incentive program for the purpose of providing financial incentives to eligible primary care providers who meet the criteria described in subsections (3) and (4) of this section. The financial incentives awarded under this section may include, but are not limited to, educational loan repayment subsidies.

(3) In order to be eligible to receive financial incentives under this section, a primary care provider shall:

(a) Practice in a health care clinic that meets the eligibility criteria described in section 7 of this 2025 Act; and

(b) Serve in their practice patients who are state medical assistance program enrollees or Medicare enrollees in a proportion that is substantially equivalent to the proportion of those patients in the geographical area in which the primary care provider practices.

(4) Any additional eligibility criteria specified by the authority by rule must allow an eligible primary care provider to qualify for multiple health care provider incentives, to the extent permitted by federal law.

(5) In providing financial incentives under this section, the authority shall:

(a) Prioritize those eligible primary care providers who practice in a federally designated health professional shortage area; and

(b) Structure the financial incentives in a manner that encourages a primary care provider who receives a financial incentive to continue practicing in a health care clinic and geographical area described in subsection (3) of this section.

(6) The authority may receive gifts, grants or other contributions from any source, whether public or private, to carry out the provisions of this section. Moneys received under this section shall be deposited in the Primary Care Expansion Fund established under section 9 of this 2025 Act.

SECTION 9. The Primary Care Expansion Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Primary Care Expansion Fund shall be credited to the fund. The fund consists of moneys appropriated to the fund by the Legislative Assembly and gifts, grants or other moneys contributed to the fund by any source, whether public or private. Moneys in the fund are continuously appropriated to the Oregon Health Authority to carry out sections 7 and 8 of this 2025 Act.

SECTION 10. ORS 646.608, as amended by section 6, chapter 410, Oregon Laws 2023, is amended to read:

646.608. (1) A person engages in an unlawful practice if in the course of the person's business, vocation or occupation the person does any of the following:

(a) Passes off real estate, goods or services as the real estate, goods or services of another.

(b) Causes likelihood of confusion or of misunderstanding as to the source, sponsorship, approval, or certification of real estate, goods or services.

(c) Causes likelihood of confusion or of misunderstanding as to affiliation, connection, or association with, or certification by, another.

(d) Uses deceptive representations or designations of geographic origin in connection with real estate, goods or services.

(e) Represents that real estate, goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, quantities or qualities that the real estate, goods or services do not have or that a person has a sponsorship, approval, status, qualification, affiliation, or connection that the person does not have.

(f) Represents that real estate or goods are original or new if the real estate or goods are deteriorated, altered, reconditioned, reclaimed, used or secondhand.

(g) Represents that real estate, goods or services are of a particular standard, quality, or grade, or that real estate or goods are of a particular style or model, if the real estate, goods or services

are of another.

(h) Disparages the real estate, goods, services, property or business of a customer or another by false or misleading representations of fact.

(i) Advertises real estate, goods or services with intent not to provide the real estate, goods or services as advertised, or with intent not to supply reasonably expectable public demand, unless the advertisement discloses a limitation of quantity.

(j) Makes false or misleading representations of fact concerning the reasons for, existence of, or amounts of price reductions.

(k) Makes false or misleading representations concerning credit availability or the nature of the transaction or obligation incurred.

(L) Makes false or misleading representations relating to commissions or other compensation to be paid in exchange for permitting real estate, goods or services to be used for model or demonstration purposes or in exchange for submitting names of potential customers.

(m) Performs service on or dismantles any goods or real estate if the owner or apparent owner of the goods or real estate does not authorize the service or dismantling.

(n) Solicits potential customers by telephone or door to door as a seller unless the person provides the information required under ORS 646.611.

(o) In a sale, rental or other disposition of real estate, goods or services, gives or offers to give a rebate or discount or otherwise pays or offers to pay value to the customer in consideration of the customer giving to the person the names of prospective purchasers, lessees, or borrowers, or otherwise aiding the person in making a sale, lease, or loan to another person, if earning the rebate, discount or other value is contingent upon an event occurring after the time the customer enters into the transaction.

(p) Makes any false or misleading statement about a prize, contest or promotion used to publicize a product, business or service.

(q) Promises to deliver real estate, goods or services within a certain period of time with intent not to deliver the real estate, goods or services as promised.

(r) Organizes or induces or attempts to induce membership in a pyramid club.

(s) Makes false or misleading representations of fact concerning the offering price of, or the person's cost for real estate, goods or services.

(t) Concurrent with tender or delivery of any real estate, goods or services, fails to disclose any known material defect or material nonconformity.

(u) Engages in any other unfair or deceptive conduct in trade or commerce.

(v) Violates any of the provisions relating to auction sales, consignment sales, auctioneers, consignees or auction marts under ORS 698.640, whether in a commercial or noncommercial situation.

(w) Manufactures mercury fever thermometers.

(x) Sells or supplies mercury fever thermometers unless the thermometer is required by federal law, or is:

(A) Prescribed by a person licensed under ORS chapter 677; and

(B) Supplied with instructions on the careful handling of the thermometer to avoid breakage and on the proper cleanup of mercury should breakage occur.

(y) Sells a thermostat that contains mercury, unless the thermostat is labeled in a manner to inform the purchaser that mercury is present in the thermostat and that the thermostat may not be disposed of until the mercury is removed, reused, recycled or otherwise managed to ensure that the

mercury does not become part of the solid waste stream or wastewater. For purposes of this paragraph, "thermostat" means a device commonly used to sense and, through electrical communication with heating, cooling or ventilation equipment, control room temperature.

(z) Sells or offers for sale a motor vehicle manufactured after January 1, 2006, that contains mercury light switches.

(aa) Violates the provisions of ORS 803.375, 803.385 or 815.410 to 815.430.

(bb) Violates ORS 646A.070 (1).

(cc) Violates any requirement of ORS 646A.030 to 646A.040.

(dd) Violates the provisions of ORS 128.801 to 128.898.

(ee) Violates ORS 646.883 or 646.885.

(ff) Violates ORS 646.569 or 646A.374.

(gg) Violates the provisions of ORS 646A.142.

(hh) Violates ORS 646A.360.

(ii) Violates ORS 646.553 or 646.557 or any rule adopted pursuant thereto.

(jj) Violates ORS 646.563.

(kk) Violates ORS 759.680 or any rule adopted pursuant thereto.

(LL) Violates the provisions of ORS 759.705, 759.710 and 759.720 or any rule adopted pursuant thereto.

(mm) Violates ORS 646A.210 or 646A.214.

(nn) Violates any provision of ORS 646A.124 to 646A.134.

(oo) Violates ORS 646A.095.

(pp) Violates ORS 822.046.

(qq) Violates ORS 128.001.

(rr) Violates ORS 646A.800 (2) to (4).

(ss) Violates ORS 646A.090 (2) to (5).

(tt) Violates ORS 87.686.

(uu) Violates ORS 646A.803.

(vv) Violates ORS 646A.362.

(ww) Violates ORS 646A.052 or any rule adopted under ORS 646A.052 or 646A.054.

(xx) Violates ORS 180.440 (1) or 180.486 (1).

(yy) Commits the offense of acting as a vehicle dealer without a certificate under ORS 822.005.

(zz) Violates ORS 87.007 (2) or (3).

(aaa) Violates ORS 92.405 (1), (2) or (3).

(bbb) Engages in an unlawful practice under ORS 646.648.

(ccc) Violates ORS 646A.365.

(ddd) Violates ORS 98.853, 98.854, 98.856 or 98.858.

(eee) Sells a gift card in violation of ORS 646A.276.

(fff) Violates ORS 646A.102, 646A.106 or 646A.108.

(ggg) Violates ORS 646A.430 to 646A.450.

(hhh) Violates a provision of ORS 744.318 to 744.384.

(iii) Violates a provision of ORS 646A.702 to 646A.720.

(jjj) Violates ORS 646A.530 30 or more days after a recall notice, warning or declaration described in ORS 646A.530 is issued for the children's product, as defined in ORS 646A.525, that is the subject of the violation.

(kkk) Violates a provision of ORS 697.612, 697.642, 697.652, 697.662, 697.682, 697.692 or 697.707.

(LLL) Violates the consumer protection provisions of the Servicemembers Civil Relief Act, 50 U.S.C. 3901 et seq., as in effect on January 1, 2010.

(mmm) Violates a provision of ORS 646A.480 to 646A.495.

(nnn) Violates ORS 646A.082.

(ooo) Violates ORS 646.647.

(ppp) Violates ORS 646A.115.

(qqq) Violates a provision of ORS 646A.405.

(rrr) Violates ORS 646A.092.

(sss) Violates a provision of ORS 646.644.

(ttt) Violates a provision of ORS 646A.295.

(uuu) Engages in the business of, or acts in the capacity of, an immigration consultant, as defined in ORS 9.280, in this state and for compensation, unless federal law authorizes the person to do so or unless the person is an active member of the Oregon State Bar.

(vvv) Violates ORS 702.012, 702.029 or 702.054.

(www) Violates ORS 646A.806.

(xxx) Violates ORS 646A.810 (2).

(yyy) Violates ORS 443.376.

(zzz) Violates a provision of ORS 646A.770 to 646A.787.

(aaaa) Violates ORS 815.077.

(bbbb) Violates ORS 743B.287.

(2) A representation under subsection (1) of this section or ORS 646.607 may be any manifestation of any assertion by words or conduct, including, but not limited to, a failure to disclose a fact.

(3) In order to prevail in an action or suit under ORS 336.184 and 646.605 to 646.652, a prosecuting attorney need not prove competition between the parties or actual confusion or misunderstanding.

(4) An action or suit may not be brought under subsection (1)(u) of this section unless the Attorney General has first established a rule in accordance with the provisions of ORS chapter 183 declaring the conduct to be unfair or deceptive in trade or commerce.

(5) Notwithstanding any other provision of ORS 336.184 and 646.605 to 646.652, if an action or suit is brought under subsection (1)(xx) of this section by a person other than a prosecuting attorney, relief is limited to an injunction, and the prevailing party may be awarded reasonable attorney fees.

SECTION 11. Section 2 of this 2025 Act applies to contracts between a coordinated care organization and the Oregon Health Authority entered into, amended or renewed on or after the effective date of this 2025 Act.

SECTION 12. The amendments to ORS 743B.287 by section 3 of this 2025 Act apply to claim submissions for reimbursements by providers offered, amended or renewed on or after the effective date of this 2025 Act.