

Amendments to SB 27

DRAFT

April 7, 2007

A BILL FOR AN ACT

Whereas the objective of our health care system is health, not just the financing and delivery of health care services; and

Whereas health is more than just the absence of physical and mental disease; it is the product of a number of factors, only one of which is access to our medical system; and

Whereas persons with disabilities and other ongoing conditions can also live long and healthy lives; and

Whereas we cannot achieve the objective of health unless all individuals have timely access to the effective treatment of a defined set of essential health conditions; and

Whereas we cannot achieve the objective of health unless we invest not only in health care, but also in education, economic opportunity, housing, sustainable environmental stewardship, full participation and other areas which are important contributing factors to health; and

Whereas the escalating cost of health care is compromising our ability to invest in those other areas that contribute to the health of the population; and

Whereas we cannot achieve our objective of health unless we can control costs in the health care system; and

Whereas we cannot control costs unless we:

(1) Develop effective strategies through education of individuals and health care providers, development of policies and practices as well as financial incentives and disincentives to empower individuals to assume more personal responsibility for their own health status through the choices they make;

(2) Reevaluate the structure of our 50-year federal financing and eligibility system in light of the realities and circumstances of the 21st century and of what we want the system to achieve from the standpoint of the health of our population; and

(3) Rethink how we define a "benefit" and restructure the misaligned financial incentives and inefficient system through which health care is currently delivered; and

Whereas public resources are finite, and therefore the public resources available for health care are also finite; and

Whereas finite resources require that explicit priorities be set through an open process with public input on what should and should not be financed with public resources; and

Whereas those with more disposable private income will always be able to purchase more health care than those who depend solely on public resources; and

Whereas the current health care system is unsustainable in large part because of outdated federal policies that reflect the realities of the last century instead of the realities of today and which are based on assumptions that are no longer valid; and

Whereas the ability of states to maintain the public's health is increasingly constrained by those federal policies, which were built around "categories" rather than a commitment to ensure all citizens have timely access to the effective treatment of essential health conditions; and

Whereas public subsidies of employer-sponsored health coverage under the Tax Reform Act of 1954, Medicaid and Medicare, which were established through three specific acts of Congress in the last century, were enacted separately at different times for different reasons and reflect no sense of common purpose; and

Whereas the economic and demographic environment in which those federal programs were created has changed dramatically over the past 50 years, while the programs themselves continue to reflect a set of circumstances that existed in the mid-20th century; and

Whereas any reform effort that fails to address the contradictions and inequities embodied in the federal programs and fails to bring them into alignment with the realities of the 21st century will also fail to achieve meaningful reform, perpetuating the status quo and the contradictions, inequities and consequences existing in the current system; and

Whereas any strategies for financing, mandating or developing new programs to expand access must address what will be covered with public resources and how those services will be delivered. Otherwise, those strategies will do little to stem escalating medical costs, make health care more affordable or create a sustainable system; and

Whereas Oregon must take immediate action to develop, for consideration by the United States Congress, a proposed alternative to the way public dollars are currently being spent on health care within the state in order to create a sustainable system which will optimize the health of Oregonians; **now,**
therefore,

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

SECTION 1. Sections 2 to 20 of this 2007 Act and ORS X, X, X, and X, as amended by sections X to X of this 2007 Act, shall be known as the Oregon Better Health Act.

SECTION 2. It is the intent of the Legislative Assembly in enacting the Oregon Better Health Act to:

(1) Ensure that all Oregonians have timely access to treatment for a defined set of essential health conditions;

(2) Offer a blueprint for national health care reform;

(3) Recognize that clinging to the system of employer-sponsored coverage as it is currently structured is not an option and to:

(a) Recognize that the current structure makes much less sense now than it did when the economic forces and incentives that created it were put in place over 50 years ago;

(b) Rethink the structure of the current system of employer sponsored coverage in light of the realities of a highly competitive global economy, the increased mobility of the workforce and the changing structure of the workplace; and

(c) Develop a way to finance the treatment of a defined set of essential health conditions that are not tied to employment, relieving employers and employees of this cost while still leaving employers the option of offering secondary coverage designed to best serve the specific needs of their particular workforce;

(4) Recognize that clinging to the current structure of Medicaid, including the Title XIX Medicaid health care benefit, is not an option and to:

(a) Eliminate the need for a special program for the poor by ensuring that all Oregonians, including the most vulnerable members of our society, have access to treatment for at least the same defined set of essential health conditions;

(b) Ensure that the medical and health needs of the blind and those with other disabilities and special needs are met in a timely and cost effective manner with treatments that are physically and cognitively accessible and that produce quality outcomes; and

(c) Eliminate the complexity and administrative cost of assigning equally impoverished and vulnerable groups of Oregonians into dozens of different eligibility categories to determine how their care will be financed; and

(5) Reconsider the current structure of the Medicare program, but not to dismantle it, and to:

(a) Recognize that clinging to the current structure of Medicare is not an option;

(b) Rethink the current structure of Medicare in light of the huge demographic trends and advances in medical technology that have taken place since it was created in 1966;

(c) More rationally and honestly identify the medical and health needs of an aging population and to ensure that those needs are met in a timely and cost-effective manner with treatments that are physically and cognitively accessible and that produce quality outcomes; and

(d) Balance, in an equitable and sustainable manner, the medical and health needs of the elderly with those of the non elderly and ensure that this balance is reflected in the allocation of public resources for health care.

(6) Reconsider the workforce capacity in the current system, in order to move to more effective and efficient delivery models that will produce quality outcomes.

SECTION 3. The Oregon Better Health Act is based on the following principles:

(1) Equity. All individuals must be eligible for and have timely access to effective treatment for at least the same set of essential health conditions.

(2) Financing. Financing of the health care system must be equitable, broadly based and affordable.

(3) Population benefit. The public must be engaged in identifying priorities to optimize the health of Oregonians.

(4) Responsibility. Responsibility for optimizing health must be shared by individuals, employers, health systems and communities.

(5) Education. Education is a powerful tool for health promotion. The health care system must promote and engage in education activities for individuals, health systems and communities.

(6) Choice and Dignity. Health care and health promotion systems must provide services in ways that support choice and dignity for individuals.

(7) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence when possible. When evidence based practice is not possible, health interventions and their desired outcomes must reflect successful clinical practice.

(8) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.

(9) **Explicit decision-making.** Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.

(10) **Transparency.** The evidence used to support decisions must be clear, understandable and observable to the public.

(11) **Economic sustainability.** Health service expenditures must be managed to ensure sustainability over the long term, using efficient planning, budgeting and coordination of resources and reserves, based on public values that respect the inherent worth of all Oregonians and recognizing the impact that public and private health expenditures have on each other.

(12) **Aligned financial incentives.** Financial incentives must be aligned to support and invest in activities that will achieve the goals of this 2007 Act.

(13) **Wellness.** Health and wellness promotion efforts must be emphasized and strengthened.

(14) **Community-based.** The delivery of care and distribution of resources must be organized to take place at the community level, unless outcomes or cost can be improved at regional or statewide levels.

(15) **Coordination.** Collaboration, coordination and integration of care and resources must be emphasized throughout the health system.

SECTION 4. (1) The Oregon Better Health Trust Fund is established separate and distinct from the General Fund. Interest earned from the investment of moneys in the Oregon Better Health Trust Fund shall be credited to the fund. The Oregon Better Health Trust Fund shall include:

- a) State funds made available by the Oregon Legislative Assembly for purposes that are consistent with the goals of this 2007 Act.

- b) Federal funds from Title XVIII, XIX or XXI of the Social Security Act that may be made available to the fund by the federal government;
 - c) Contributions from any other source, public or private, appropriated to the fund by the Legislative Assembly for the purpose of administering this 2007 Act.
- (2) All moneys in the Oregon Better Health Trust Fund are continuously appropriated for the purpose of providing health services to all Oregon residents.

SECTION 5. (1) There is established the Oregon Better Health Design Board to develop a blueprint for national reform. The board shall consist of eleven members appointed by the Governor, subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution. The members of the Board must include individuals with actuarial and financial management experience, individuals who are providers of health care and individuals who are consumers of health care, including seniors, people with disabilities and people with complex medical needs.

(2) Each board member shall serve a concurrent term which will expire on July 1, 2009.

(3) If there is a vacancy for any cause, the Governor shall make an appointment to become effective immediately for the balance of the unexpired term.

(4) Members of the board are in the exempt service under ORS chapter 240, and the Governor shall fix their salaries in accordance with ORS 240.245.

(5) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(6) A majority of the members of the board constitutes a quorum for the transaction of business.

(7) Official action by the board requires the approval of a majority of the members of the board.

(8) The Oregon Better Health Design Board will sunset on July 1, 2009.

SECTION 6. (1) The Oregon Better Health Design Board shall appoint an executive director to serve at the pleasure of the board.

(2) The designation of the executive director must be by written order filed with the Secretary of State.

(3) Subject to any applicable provisions of ORS chapter 240, the executive director is authorized to hire, supervise and terminate the employees of the board, prescribe their duties and fix their compensation.

SECTION 7. The Oregon Better Health Design Board shall:

(1) Develop a plan to ensure that all Oregonians have access to treatment for a defined set of essential health conditions;

(2) Offer a proposal to implement the plan for consideration by the United States Congress as the basis for national health care reform;

(3) Oversee the actuarial process described in ORS 414.720 (6) to define the set of essential health conditions;

(4) Conduct public hearings to determine the adequacy of the defined set of essential health conditions in meeting the goals of the Oregon Better Health Act;

(5) Establish a subcommittee to develop options, using the criteria in section 8 of this 2007 Act, for a mechanism to transfer the value of the public subsidy of employer-sponsored coverage through state and federal tax expenditures to the Oregon Better Health Trust Fund. The subcommittee must include both small and large business interests, including those offering coverage, those not offering coverage and those that are

self-insured, employees of those businesses, included those belonging to Taft Hartley Trusts, and self-employed individuals;

(6) Establish a subcommittee to make recommendations on the most efficient and effective delivery system models producing quality outcomes for consideration in the actuarial process described in ORS 414.720 (6). Membership must include, but not be limited to, primary care physicians, specialists, nurses, advanced practice nurses, mental health and chemical dependency providers, dentists and providers from community health organizations, public health rural health clinics, individuals with community based health promotion and prevention programs and consumers of health care;

(7) Establish a subcommittee to make recommendations on how best to maximize the integration of health services with community based long term care services to avoid disruptions in care. Membership shall include, but not be limited to providers of community based long term care services, seniors, people with developmental disabilities, people with physical disabilities, people with chronic health conditions and people with complex medical needs.

(8) Establish a subcommittee to develop options to finance and implement the health information technology services and infrastructure described in section 11 of this 2007 Act;

(9) Establish a subcommittee to develop options to promote healthy behaviors through strategies that focus on both individual choices and environmental influences. These strategies shall include empowering individuals through education as well as financial incentives and disincentives to assume more personal responsibility for their own health status. Recognizing the powerful role that the social environment plays in health outcomes, the subcommittee shall also make recommendations regarding strategies to create

environments that support, reinforce, and enable healthy behaviors. Membership shall include consumers of health care including seniors, people with disabilities, and people with complex medical needs. The subcommittee shall consider the recommendations of the Health Services Commission concerning investments in non clinical services and programs that have a bearing on the health of all in the population as required in ORS 414.720 (4)(e). The Oregon Better Health Design Board shall submit these options to an independent actuary to determine the cost of implementation and incorporate them into the plan developed under section 14 of this 2007 Act;

(5) Establish a subcommittee to make recommendations concerning how to address the issue of medical liability including, but not limited to, a consideration of the implementation of a Medical Review Panel and a Patient's Compensation Fund, and providing liability protection for those providers who adhere to established best-practice standards and guidelines.

SECTION 8. The mechanism to transfer the value of the public subsidy of employer-sponsored coverage to the Oregon Better Health Trust Fund must:

(1) Not create an incentive for employers to discontinue coverage through the workplace;

(2) Address the inequities between employers that do and do not offer coverage;

(3) Recognize that small employers may have less margin with which to contribute to the cost of their employees' health care; and

(4) Take into account the global economy, the mobility of the workforce and the changing structure of the workplace.

SECTION 9. For the purpose of the developing the plan described in Section 14 of this 2007 Act, the Oregon Better Health Design Board shall assume that;

(1) the Oregon Better Health Board described under section 15 of this Act will enter into contracts with privately and publicly sponsored health care organizations for the treatment of the defined set of essential health conditions developed in ORS 414.720. The health care organizations shall include, but are not limited to, private health plans and insurers, health care service contractors, independent practice associations, managed care health services organizations, community clinics, community health centers, rural health clinics and federally qualified health centers.

(2) The contracts must include standards for quality, performance and transparency, including transparency in costs, charges and outcomes.

(3) All Oregonians must be covered for the treatment of the same defined set of essential health conditions and the capitation rate must be the same for all contracting health care organizations.

(4) The health care organizations must be community-rated and must compete with each other to enroll Oregonians on the basis of outcomes, service and the secondary coverage described in subsection (9) of this section.

(5) There must be no underwriting. Instead, each contract shall contain a risk-adjusted formula.

(6) The board shall establish a minimum medical loss ratio for the health care organizations.

(7) The board may create a high-risk pool spread over the entire population to help subsidize those health care organizations that assume more risk.

(8) Individuals may choose their own health care organization or employers may continue to serve as health insurance distributors for their employees.

(9) Health care organizations may offer secondary coverage for services not included in the treatment of the defined set of essential health conditions, but to do so they must also offer coverage for the treatment of the defined set of essential set of health conditions.

SECTION 10. For the purpose of the developing the plan described in Section 14 of the Act, the Oregon Better Health Design Board shall assume that:

(1) Individuals or employers may supplement coverage of the treatment of the defined set of essential health conditions financed by the Oregon Better Health Trust Fund by purchasing secondary coverage from health care organizations.

(2) Secondary coverage must be separate and distinct from coverage for the treatment of the defined set of essential health conditions.

(3) The cost of secondary coverage purchased under this section may not be deducted from state income taxes.

SECTION 11. For the purpose of the developing the plan described in Section 14 of the Act, the Oregon Better Health Design Board shall (1) Encourage the use of information technology that is cost-neutral or has a positive return on investment, to deliver efficient, safe, quality care; and

(2) Include a voluntary program to provide every Oregonian with a personal health record. The personal electronic health record must be owned by the individual who will control the use of and access to the information stored in it. The personal electronic health record must be portable and not tied to a health care organization, employer or governmental entity.

SECTION 12. Within 60 days of the passage of this 2007 Act;

(1) The Oregon Better Health Design Board and the Health Services Commission shall begin the benefit design process described in ORS 414.720 of establishing priorities among health conditions and determining the cost of treating a defined set of essential health conditions for which all Oregonians are eligible.

(2) The Oregon Better Health Design Board shall establish the six subcommittees described in section 7 of this 2007 Act to begin to carry out their charges.

SECTION 13. (1) For the purpose of the benefit design process described in subsection (1) of section 12 of this Act, the Oregon Better Health Design Board and the Health Services Commission shall assume that the resources available to the Oregon Better Health Trust Fund will be the total value of the following funds currently being spent on health care each year in Oregon:

(a) Medicare funds under Title XVIII of the Social Security Act, assuming the national average reimbursement rate;

(b) Medicaid funds under Title XIX of the Social Security Act used to fund the Oregon Health Plan and other medical services and administration;

(c) General Fund moneys that would otherwise be spent in the Medicaid program; and

(d) The value of state and federal tax expenditures for employer-sponsored health insurance coverage.

(2) The funds described in subsection (1) of this section shall not include funds currently being spent on long term care services.

SECTION 14. (1) Based upon the recommendations of the six sub-committees described in section 7 of this 2007 Act, the Oregon Better Health Design Board shall develop a plan to implement the provisions of the Oregon Better Health Act for

consideration by the United States Congress as the basis for national health care reform.

(2) In developing the plan described in subsection (1) of this section, the board shall conduct public hearings and solicit testimony and information from advocates representing seniors, persons with disabilities, consumers of mental health services, low-income Oregonians, employers, employees, insurers and health plans and providers of health care including, but not limited to, physicians, specialists, nurses, advanced practice nurses, mental health and chemical dependency providers, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, and other allied health professionals.

(3) The plan shall detail:

(a) The administrative and governing structures of the new system on both the state and community levels;

(b) The structure of the delivery system, including standards for quality transparency and accountability as well as performance measures; and

(c) The actuarial process used to determine the cost of treating the defined set of essential health conditions to produce quality outcomes and to align the financial incentives in the system with the purposes and principles of the Oregon Better Health Act expressed in section 2 and section 3 of this 2007 Act.

(4) The board shall develop a transition plan that details the changes, resources and time frames necessary to make an orderly transition from the current system to the new system.

(5) The board shall conduct public hearings on the proposed plan.

(6) The board shall finalize the plan based upon information provided in the public hearings in subsection (5) of this section and submit the plan to the Governor for approval.

SECTION 15. (1) The plan developed under section 14 of this Act shall include recommendations for the appointment of a permanent Oregon Better Health Board. The recommendations shall detail the structure, membership and responsibilities of the permanent board. Among these responsibilities, the board shall:

- (a) Manage the Oregon Better Health Trust Fund;
- (b) Oversee the actuarial process described in ORS 414.720 (6) to define the set of essential health conditions;
- (c) Conduct public hearings to determine the adequacy of the defined set of essential health conditions in meeting the goals of this 2007 Act;
- (d) Contract with privately and publicly sponsored health care organizations in accordance with section 9 of this 2007 Act.

(2) The board shall be modeled after the federal reserve board to give it as much independence as possible.

SECTION 16. The Governor shall present the plan developed under section 15 of the Act as a legislative proposal to the next regular or special session of the Legislative Assembly following the Governor's approval of the plan. The legislative proposal shall:

- (1) Request that the Oregon Congressional delegation submit federal legislation which reflects the plan;
- (2) Request federal authority to implement portions of the plan as pilot projects including but not limited to:
 - (a) Application to the Secretary of the Department of Health and Human Services for waivers to implement pilot projects within the Medicare program based on the plan so long as such waivers do not request the administration of Medicare funds by a state agency;
 - (b) Application to the Secretary of the Department of Health and Human Services for Medicaid waivers to conduct Medicaid Demonstration projects based on the plan.

SECTION 17. ORS 414.707 is amended to read:

414.707. (1) Subject to funds available:

(a) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o), and persons under 19 years of age and pregnant women who are eligible to receive health services under ORS 414.706, are eligible to receive all the health services approved and funded by the Legislative Assembly.

(b) Persons described in ORS 414.708 are eligible to receive the health services described in ORS 414.705 (1)(c), (f) and (g).

(c) Persons 19 years of age and- older who are eligible to receive health services under ORS 414.706 are eligible to receive the health services described in ORS 414.705 (1)(b) to (m).

(2) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o), and persons under 19 years of age and pregnant women who are eligible to receive health services under ORS 414.706, must be provided, at a minimum, the health services described in ORS 414.705 (l)(a) to (g).

(3) Persons 19 years of age and older who are eligible to receive health services under ORS 414.706 must be provided, at a minimum, health services described in ORS 414.705 (l)(b) to (h).

(4) Persons described in ORS 414.708 must be provided, at a minimum, the health services described in ORS 414.705 (1)(c).

[(5) The Department of Human Services shall:]

[(a) Develop at least three benefit packages of provider services to be offered under ORS 414.705 (1)0); and]

[(b) Define by rule the services to be offered under ORS 414.705 (1)(k).]

[(6) Notwithstanding ORS 414.735, the Legislative Assembly shall adjust health services funded under ORS 414.705 (1) by increasing or reducing benefit packages or health services and, subject to ORS 414.709, by increasing or reducing the population of eligible persons].

SECTION 18. ORS 414.720 is amended to read:

414.720. (1) The Health Services Commission shall conduct public hearings prior to making the report described in subsection (3) of this section. The commission shall solicit testimony and

information from advocates representing seniors, persons with disabilities, mental health services consumers and low-income Oregonians, representatives of commercial carriers, representatives of small and large Oregon employers and providers of health care, including but not limited to, physicians, specialists, nurses, advanced practice nurses, mental health and chemical dependency providers, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, and other allied health professionals.

(2) The commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.

(3) Using a transparent process, the commission shall establish priorities from among health conditions, including physical, dental, vision, mental and chemical dependency, in 10 categories:

- (a) Prevention;**
- (b) Pregnancy and childbirth;**
- (c) Acute life-threatening conditions;**
- (d) Acute non-life-threatening self-limiting conditions;**
- (e) Catastrophic conditions;**
- (f) Chronic life-threatening conditions;**
- (g) Chronic non-life-threatening conditions;**
- (h) End of life;**
- (i) Rehabilitation; and**
- (j) Elective conditions.**

(4) The commission shall establish priorities among the categories and within each category, from the most important to the least important based upon the comparative health benefit of treating each condition for optimizing the health of all in the population and based on criteria that have been publicly debated and agreed upon by the Oregon Health Fund Board including, but not limited to:

- (a) Social values that respect the inherent worth of all Oregonians;**

(b) Clinical effectiveness of the treatment of the condition to produce quality outcomes;

(c) The degree to which medical evidence exists to support the relationship between the treatment and the desired quality health outcome when possible. When evidence based practice is not possible, health interventions and their desired outcomes must reflect successful clinical practice.

(d) The relative cost-effectiveness of drugs, procedures and technologies in terms of the health benefit for the entire population served; and

(e) Investments needed in non clinical services and programs that have a bearing on the health of the population.

[(3)] (5) For the purpose of the benefit design process described in subsection (1) of section 12 of this Act, the commission shall report to the *[Governor]* **Oregon Better Health Design Board** a list of essential health *[services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to]* **conditions ranked by priority from the most important to the least important based upon the comparative health benefit of treatment of each condition for optimizing the health of the entire population to be served.** The list submitted by the commission pursuant to this subsection is not subject to alteration by any other state agency. The recommendation may include practice guidelines reviewed and adopted by the commission pursuant to subsection (4) of this section.

[(4)] In order to encourage effective and efficient medical evaluation and treatment, the commission:]

[(a)] May include clinical practice guidelines in its prioritized list of services. The commission shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical practice guidelines developed by the commission.]

[(b)] Shall consider both the clinical effectiveness and cost-effectiveness of health services in determining their relative

importance using peer-reviewed medical literature as defined in ORS 743.695.]

[(5) The commission shall make its report by July 1 of the year preceding each regular session of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Representatives and the President of the Senate.]

[(6) The commission may alter the list during interim only under the following conditions:]

[(a) Technical changes due to errors and omissions; and]

[(b) Changes due to advancements in medical technology or new data regarding health outcomes.]

[(7) If a service is deleted or added and no new funding is required, the commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the commission must report to the Emergency Board to request the funding.]

[(8) The report listing services to be provided pursuant to ORS 414.036, 414.042, 414.065, 414.107, 414.705 to 414.725 and 414.735 to 414.750 shall remain in effect from October 1 of the odd-numbered year through September 30 of the next odd-numbered year.]

(6)(a) The Better Health Design Board shall be responsible for supervising an independent actuarial process to determine the cost of treating each condition on the list to produce quality outcomes.

(b) The board must develop the assumptions used in the actuarial process with the involvement and input of affected persons including, but not limited to, consumers of health care, employers, hospitals, primary care physicians, specialists, nurses, advanced practice nurses, mental health providers, dentists and providers from community health centers and rural health clinics.

(c) The board must base actuarial assumptions concerning utilization of services upon the most efficient and effective delivery system models producing quality outcomes, particularly for the management of chronic conditions.

(d) The actuarial assumptions developed by the board under paragraph (b) of this subsection must include the following:

(A) Providers must receive fair and reasonable payments that are stable and predictable for the covered set of essential health conditions to produce quality outcomes. Payments may include payment for other than face-to-face encounters with providers.

(B) Payment levels must take into account the need to create incentives that ensure adequate workforce capacity to meet the requirements of the most efficient and effective delivery system models producing quality outcomes.

(C) There must be value based cost-sharing for consumers, with lower or no cost sharing for the treatment of conditions that are higher on the priority list, particularly when the treatment is highly effective in producing quality outcomes, and with higher cost-sharing burdens for the treatment of elective, discretionary conditions and conditions that are lower on the priority list.

(7) The Better Health Design Board shall determine the defined set of essential health conditions by:

(a) Dividing the Oregon Better Health Trust Fund by the eligible population to arrive at a capitation rate, adjusted for population characteristics using standard actuarial principles; and

(b) Applying the capitation rate to the list described in subsection (5) of this section.

SECTION 19. ORS 414.735 is amended to read:
414.735. For the purpose of the developing the plan described in section 14 of the Act, the Better Health Design Board will assume that:

(1) If moneys accumulate in excess of the legislatively adopted budget for the Oregon Health Trust Fund during a biennium, the Oregon Better Health Board described in section 15 of this 2007 Act may authorize

coverage for the treatment of additional health conditions from the list of conditions developed under section 18 of this 2007 Act.

[(1) If insufficient resources are available during a contract period:]

[(a) The population of eligible persons · determined by law shall not be reduced.]

(2) If the Oregon Better Health Fund is insufficient to provide treatment for the defined set of essential health conditions to all eligible persons during a biennium:

(a) The number, types or categories of persons may not be reduced by restricting eligibility requirements.

(b) The reimbursement rate for providers and health care organizations established under the contractual agreement shall not be reduced.

[(2)] **(3) In the circumstances described in subsection [(1)] (2) of this section, [reimbursement shall be adjusted by reducing the health services for the eligible population by eliminating services in the order of priority recommended by the Health Services Commission] the Oregon Better Health Board described in section 15 of this 2007 Act may:**

(a) Reduce the total cost of treatment for the defined set of essential health conditions by eliminating or modifying the treatment of conditions from the list of conditions developed under ORS 414.720, starting with the least important and progressing toward the most important[.]; or

(b) Request an additional General Fund appropriation from the Legislative Assembly.

(3) The Department of Human Services shall obtain the approval of the Legislative Assembly or Emergency Board, if the Legislative Assembly is not in session, before instituting any changes to the level of the defined set of essential health conditions. In addition, providers contracting to provide services under ORS 414.705 to 414.750 must be notified at least two weeks prior to any legislative consideration of reductions. Any reductions made under this section shall take effect no sooner

than 60 days following final legislative action approving the reductions.

SECTION 20. . ORS 414.745 is amended to read:
414.745. **For the purpose of the developing the plan described in Section 14 of the Act, the Oregon Better Health Design Board will assume that any health care provider or *[plan]* health care organization contracting to provide services to the eligible population under *[ORB 414.705 to 414.750]* section 10 of this 2007 Act, shall not be subject to criminal prosecution, civil liability or professional disciplinary action for failing to provide a service which the Legislative Assembly has not funded or the Oregon Better Health Board described in section 15 of this 2007 Act has eliminated *[from its funding]* from coverage pursuant to ORS 414.735.**

SECTION 21. There is appropriated to the Oregon Better Health Trust Fund, for the biennium beginning July 1, 2007, out of the General Fund, the amount of \$_____ for the purpose of administering the Oregon Better Health Act accordance with sections **X** to **X** of this 2007 Act.

SECTION 22. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.