

Comparison of House and Senate Health Reform Bills - 5/11/2009  
 Except where noted, House column refers to HB 2009B and Senate column refers to SB 856A

Italicized text indicates differences.				
Subject Area	Section and Page	House Version	Senate Version	Comments
Creation of Authority	House - Section 19, 13-14 and conforming sections of bill Senate: Section 22-23, pp. 14-16; Section 24, pp. 16; Sections 47-48, pp. 24-25; Section 75, pp. 59	The Authority is established as an <i>independent agency</i> and all duties, functions and powers of the Department of Human Services (DHS) <i>with respect to health care are imposed upon, transferred to and vested in the Authority including: Developing policies for publicly funded medical care and medical assistance (Division of Medical Assistance Programs - DMAP), with DHS continuing to determine eligibility for medical assistance; ensuring the promotion and protection of public health and licensing health facilities (Public Health Division); developing policies for the provision of mental health and substance abuse treatments (Addictions and Mental Health Services);</i> administering the Oregon Prescription Drug Program (OPDP); and responsibility for the Office for Health Policy and Research (OHPR). <i>DHS retains duties associated with providing assistance to individuals in long-term care, home-based and community-based care, in residential facility care for seniors, and with physical and developmental disabilities. The Public Employees' Benefits Board (PEBB) are transferred from DAS to the Authority.</i> The Oregon Medical Insurance Pool (OMIP) and its Board are transferred from DCBS. The Office of Private Health Partnerships (OPHP), including the administration of FHIAP are transferred to the Board. The Oregon Health Policy Commission is abolished. All changes necessary to accomplish these transfers will take place prior to June 30, 2011 and will be reflect in the Governor's 2011-2013 budget.	The Authority is created in DHS. The Authority is named as the State Medicaid agency and administers the Quality Institute, OPDP and FHIAP. The powers, duties, and functions of DHS (with respect to Section 24), OPHP, OEBB and PEBB are transferred to the Authority. PEBB and OEBB Boards maintain authority over contracting and promulgation of rules. <i>Public Health, Addictions and Mental Health Services, and OHPR are not called out in the legislation. By July 1, 2011, the Authority is to become an independent agency (Section 75), although Section 22(9) requires the Authority to deliver a report to the Legislature by June 1, 2010 on legislative changes needed to make the Authority independent. On or before December 31, 2012, the Authority is to report to the Legislature with recommendations and plans to move the health care purchasing functions for SPD, the juvenile justice authority and the Department of Corrections under the Authority.</i>  <i>The Health Policy Commission and the Health Fund Board are abolished.</i>	Two different views of how to create the Authority.  House version establishes the Authority upon passage but delegates duties and functions between the Authority, DHS, DCBS, and DAS during a two year transition period.  Senate version establishes the Authority within DHS, makes no statutory changes (conforming amendments) to effect the transfer of functions and requires future legislative action to complete the transfer.  The Senate version, the Authority becomes and independent state agency on July 1, 2011.  The Senate version does not move the Office for Oregon Health Policy and Research under the Authority (see Sections 24 and 47).
Delegated Authority	House - Section 20, pp. 14	On or before January 2, 2012, DHS and the Authority may delegate to each other any duties, functions or power transfers.	N/A - not necessary because the Authority is created within DHS	

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Duties of Authority	House: Section 10, pp. 9-10 Senate: Section 24, pp. 16	<p>The Authority shall:                      Carry out the policies of the Board;                      Administer a Quality Care Institute;                      Develop a plan for a Health Insurance Exchange;                      Administer the Oregon Prescription Drug Program;                      Administer the Family Health Insurance Assistance Program;                      Provide regular reports to the Board with respect to OHP health service contractors;                      Support community-centered health initiatives;                      be the state Medicaid agency;                      In consultation with DCBS, propose standards and methodologies for the review of administrative expenses of health insurers, approval of insurance rates, and enforcement of rating rules;                      Structure payments to providers serving OHP clients to reward comprehensive management of diseases, quality outcomes, and efficiency use of resources; Guide and support community three-share agreements; Develop in consultation with DCBS, one or more products designed to provide more affordable options in the small group market;</p> <p>The Authority may:                      Establish and maintain an all-claims, all-payer database;                      Develop uniform contracting standards for the purchase of health care;                      Submit directly to Legislative Council no later than October 1 of each even-numbered year requests for legislation needed to carry out work.</p> <p>Carry out the provisions of the SB45X bills.</p>	<p>The Authority shall:                      Carry out the policies of the Board;                      Administer a Quality Care Institute;</p> <p>Administer the Oregon Prescription Drug Program;                      Administer the Family Health Insurance Assistance Program;                      Provide regular reports to the Board with respect to OHP health service contractors;                      Support community-centered health initiatives;                      Be the state Medicaid agency;</p> <p>The Authority is authorized to:                      Establish and maintain a data reporting program; <i>Establish and maintain the POLST registry; and</i>  <i>Carry out programs described in other sections of the bill (discussed below).</i></p> <p>Carry out the provisions of the SB45X bills.</p>	<p>This section represents differences in the enumerated list of duties of the Authority as listed in the bills. Due to drafting differences, these lists look very different, but the subject area comparisons below are a better reflection of the actual work assigned to the Board and the Authority.</p> <p>The House version adopted the SB 45X series of bills as passed by Senate Health. In doing so gave the duties to OHPR instead of the Authority. May wish to address this.</p>

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Director of Authority	House: Section 11, pp.10; Section 14,15, pp. 11 Senate: Section 26, pp. 17	<p>The Authority is under the supervision and control of the Director. The Director is appointed by the Governor, pursuant to confirmation by the Senate, and serves at the pleasure of the Governor. May adopt rules as necessary to carry out work of the Authority. Director, deputies and authorized representatives may administer oaths, take depositions and issue subpoenas.</p> <p>The Director has the power to contract for and procure technical or other professional services, as well as obtain other services the director considers necessary or desirable including participation in organizations of state insurance supervisory officials and appointment of advisory committees. The Director can apply for, receive, and accept grants, gifts or other payments.</p>	<p>The Authority is under the supervision and control of the Director. The Director is appointed by the Governor, pursuant to confirmation by the Senate, and serves at the pleasure of the Governor. May adopt rules as necessary to carry out work of the Authority. Director, deputies and authorized representatives may administer oaths, take depositions and issue subpoenas.</p>	The Senate version does not include contracting or grant language because the Authority resides within DHS, which has those authorities.
Deputy Directors and Employees of Authority	House: Section 13, pp. 11 Senate: Section 27, pp. 17	Deputy directors are appointed by the Director and serves at the pleasure of the Director. The Director shall appoint all subordinate officers and employees of the Authority.	Deputy directors are appointed by the Director and serves at the pleasure of the Director. The Director shall appoint all subordinate officers and employees of the Authority.	
No Restraint of Trade	House: Section 23b, pp. 16; Section 1163(4), pp. 574 Senate: Section 46, pp. 23-24	<i>Protects activities of insurers working under the direction of the Authority and DCBS in developing a baseline benefits package or in the creation of the exchange do not constitute a conspiracy or restraint of trade. Protects collaboration among public payers, health insurance carriers, third party purchasers and health care providers to identify reimbursement methods to align incentives in support of PCPCH from federal and state antitrust laws.</i>	Protects collaboration among public payers, health insurance carriers, third party purchasers and health care providers to identify reimbursement methods to align incentives in support of PCPCH from federal and state antitrust laws.	The Senate version does not extend protections to the development of an Exchange.
Effects on Actions, Proceedings and Prosecutions	House - Section 22, pp. 15 Senate - Section 50, pp. 25	Transfers of duties and powers to the Authority does not affect actions, proceedings or prosecution begun before or pending at the time of transfer except that the Authority is substituted for the agency in the action, proceeding or prosecution.	Transfers of duties and powers to the Authority does not affect actions, proceedings or prosecution begun before or pending at the time of transfer except that the Authority is substituted for the agency in the action, proceeding or prosecution.	
Employee Protection	House - Section 21, pp. 14-15	For any employee of DHS, represented by a collective bargaining agreement, that is transferred to the Authority, the Authority shall continue to recognize the bargaining agreement and representative in place at the time of the transfer.	N/A	

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Effects on Liabilities, Duties and Obligations	House - Section 23, 23a, pp. 15-16 Senate - Section 51, pp. 25	States that transfers of duties and powers to the Authority does not relieve a person of liability, duty or obligations and transfers rights and obligations of agencies/programs transferred to the Authority to the Authority. States that references in law made to agencies/programs transferred to the Authority are considered to be in reference to the Authority, the Authority Board or an officer of the Authority.	States that transfers of duties and powers to the Authority does not relieve a person of liability, duty or obligations and transfers rights and obligations of agencies/programs transferred to the Authority to the Authority. States that references in law made to agencies/programs transferred to the Authority are considered to be in reference to the Authority, the Authority Board or an officer of the Authority.	
Statewide Drug Formulary	House: Section 10(2)(D), pp. 10 Senate: Section 22(7), pp. 14-15	When the Authority develops uniform contracting standards for the purchase of health care, it shall include a state wide drug formulary that may be used by publicly funded health benefit plans.	<i>The Board shall report to the 76th Legislative Assembly</i> about opportunities to develop a statewide drug formulary to be used by publicly funded health benefit plans.	House version is part of a list of issues when developing uniform contracting standards.  Senate version stands alone.
Quality Care Institute	House: Section 17a., pp. 12 Senate: Section 31, pp. 18	The Quality Care Institute is created within the Authority to develop uniform statewide health care quality standards that are designed for use by purchasers, third-party payers and health care providers as the quality performance benchmarks for Oregon.	The Quality Care Institute is created within the Authority to develop uniform statewide health care quality standards that are designed for use by purchasers, third-party payers and health care providers as the quality performance benchmarks for Oregon.	
Health Authority Fund	House: Section 18, pp. 13 Senate: Section 30, pp. 18; Section 49, pp. 24-25	The Oregon Health Authority Fund is established in the State Treasury, separate and distinct from the General Fund and should be used for carrying out duties of the Authority and the Authority Board.	The Oregon Health Authority Fund is established in the State Treasury, separate and distinct from the General Fund and should be used for carrying out duties of the Authority and the Authority Board.  <i>Transfers remaining balance from Oregon Health Fund to Oregon Health Authority Fund.</i>	Both versions establish the fund but the House version does not transfer balance of Health Fund Board Fund into the Authority.
Creation and Membership of Authority Board	House - Section 1-5, pp. 1-5 Senate: Section 1-6, pp. 2-4	Nine member board with four year initially staggered terms. The Governor appoints the Board, pursuant to confirmation by the Senate. Members must be residents of OR, demonstrate leadership, represent diversity of the state, and collectively provide expertise in consumer advocacy, management of a company that provides health insurance, public health, finance, organized labor, health care and the operation of a small business. Provides limits on board member ties with health care industry. Governor appoints the chair and vice-chair and a quorum is needed to conduct business. The Board shall meet once every month, and in every congressional district at least once every two years. Board may adopt rules.	Nine member board with four year initially staggered terms. The Governor appoints the Board, pursuant to confirmation by the Senate. Members must be residents of OR, demonstrate leadership, represent diversity of the state, and collectively provide expertise in consumer advocacy, management of a company that provides health insurance, public health, finance, organized labor, health care and the operation of a small business. Provides limits on board member ties with health care industry. Governor appoints the chair and vice-chair and a quorum is needed to conduct business. The Board shall meet once every month, and in every congressional district at least once every two years. Board may adopt rules.	In the House version, compensation for Board members is established by the Board. In the Senate version, compensation is limited by ORS 292. 495 (\$30/day)
Board Member Expenses	House - Section 1 (4), pp 1 Senate - Section 1 (4), pp. 2	The Board members are entitled to reimbursement for per diem and expenses but are not subject to the provisions of ORS 292.495 (\$30/day)		In the House version, per diem expenses for Board members is established by the Board. In the Senate version, compensation is limited by ORS 292. 495 (\$30/day)

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Duties of Board	House - Section 9, pp. 7-8 Senate - Section 6, pp. 3-4	<p>Policy-making and oversight body for the Authority. Develop and submit a plan for universal access by December 31, 2010.</p> <p><i>Develop a program to provide health insurance premium assistance to low and moderate income individuals who are legal residents of Oregon.</i></p> <p><i>Establish evidence-based clinical standards and practice guidelines that may be used by providers.</i></p> <p><i>Establish quality standards to be used by all health care purchasers, third party administrators and providers.</i></p> <p>Approve and monitor community-centered health initiatives. Establish cost containment mechanisms.</p> <p>Ensure that Oregon's workforce is sufficient in numbers and training to meet the demand.</p> <p>Work with the Oregon congressional delegation to promote changes in federal policy.</p> <p><i>Establish a health benefit package to be offered in the Health Insurance Exchange.</i></p> <p><i>Develop and submit a plans for the development of the Oregon Health Insurance Exchange and a publicly operated plan that operates in the Exchange by January 2011.</i></p> <p><i>Report on the feasibility and advisability of future changes to the health insurance market. Implementation of a system of interoperable electronic health records.</i></p> <p><i>Structuring reimbursement rates to reward comprehensive management of disease, quality outcomes and the efficiency use of resources.</i></p> <p><i>Oversee expenditures of funds from the Health Care Workforce Strategic Fund.</i></p> <p><i>The Board can reorganize the authority, submit requests for legislation directly to Legislative Council, and request federal waivers needed to carry out the work of the Board.</i></p>	<p>Policy-making and oversight body for the Authority. Develop and submit a plan for universal access by December 31, 2010.</p> <p>Establish quality standards to be used by all health care purchasers, third party administrators and providers.</p> <p>Establish cost containment mechanisms.</p> <p>Work with the Oregon congressional delegation to promote changes in federal policy.</p> <p>Review and implement statewide HIT plan.</p> <p>Provide oversight for statewide workforce policy.</p> <p>Carry out all other policy programs assigned to Board.</p> <p>The Board can reorganize the authority and request federal waivers needed to carry out work.</p>	<p>House version has detailed list of duties for Board. It also has duties imposed on Board with the addition of the SB 45X series of bills that are not enumerated in this list.</p> <p>Senate version has fewer duties enumerated for Board but many of the House responsibilities are listed in separate sections of the bill. The Senate version also has duties imposed on the Board by the addition of the SB 45X series of bills, some of which are enumerated in this list.</p>

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Councils and Cooperatives and Committees	House: Section 7, pp. 5-7, Section 1168-1173, pp. 577-578 Senate: Section 7, pp. 4-6	Creates Public Health Benefit Purchasers Committee and describes specific membership. Creates a Health Care Workforce Committee. Creates the <i>11-member Governor-appointed</i> Health Information Technology Oversight Council within the Authority and <i>describes membership and terms</i> . Establishes the 15 member patient-centered primary care home advisory committee appointed by the Director defines broad membership of the committee. Creates POLST registry advisory committee and defines membership and terms. Committee members are entitled only to travel reimbursement.	Creates the Public Employers Health Cooperative,  Creates a Health Care Workforce Cooperative, Creates the Health Information Technology Oversight Council.  Establishes the patient-centered primary care home advisory committee.  Creates POLST registry advisory committee and defines membership and terms. Cooperative and council members are only entitled to travel reimbursement.	Generally both versions create the same committees and advisory councils of the Board.  The House is more prescriptive in its membership.  The Senate lets the Board determine membership, terms and organization of the committees and councils.
Advisory and Technical Committees	House: Section 8, p. 7; Section 1163, p. 573-574; Section 1181-1190, pp. 581-583 Senate: Section 8, pp. 6; Section 36-45, pp. 21-23	The Board may establish advisory and technical committees as needed and shall determine the representation, membership, terms and organization of the committees. Members of the committees are only entitled to travel reimbursement.	The Board may establish advisory and technical committees as needed and shall determine the representation, membership, terms and organization of the committees. Members of the committees are only entitled to travel reimbursement.	
Public Health Benefit Purchasers	House: Section 7(2), pp. 6 Senate: Section 7(2)(a), pp. 4	The Public Health Benefit Purchasers Committee <i>shall</i> include individuals who purchase health care for: PEBB, OEBC, Trustees of PERS, a city government, a county government, a special district and any private nonprofit that receives the majority of its funding from the state. The Committee shall develop recommendations for uniform benefit designs that are based on clinical evidence and cost-effectiveness to be used for all members of the Committee. The Authority Board and the Committee shall work together to develop steps to implement joint contract provisions. The Committee will work to minimize the cost shift to individual purchasers without shifting costs to the private sector or agencies.	The Public Employers Health Cooperative <i>may</i> include individuals who purchase health care for: PEBB, OEBC, <i>the state medical assistance program, Dept. of Corrections,</i> Trustees of PERS, a city government, a county government, a special district and any nonprofit that receives the majority of funding from the state. The Cooperative shall develop recommendations for uniform benefit designs that are based on clinical evidence and cost-effectiveness to be used by all members of cooperative (if practicable). The Authority Board and the Cooperative shall work together to develop steps to implement joint contract provisions. The Cooperative will work to minimize the cost shift to individual purchasers without shifting costs to the private sector or agencies.	Both versions establish a committee to address the purchase of health care by the state.  Membership: The House version specifies exactly who will be on the committee and is focused <b>ONLY</b> on the purchase of health care for employees of government in Oregon.  The Senate version allows the Board to select members of the Committee.  The House version does not include the state medical assistance program or the Department of Corrections in the Public Purchasers Committee.

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Health Care Workforce	House: Section 7(3), pp. 6; 7a, pp. 7; Section 7a, pp. 7; Section 9(1)(h), pp. 7-8; Section 1174-1178, pp. 578-580 Senate: Section 7(3), pp. 4-5; Section 12-17, pp. 9-11	Creates a Health Care Workforce Committee of the Board to coordinate efforts to recruit and educate health care professionals and retain a quality workforce that meets the demands that will be created by reform and changing demographics.  Adopted the provisions of SB 457 as passed by Senate Health to create and maintain a health care workforce database.  <i>The Committee shall conduct an inventory of all grants and resources available to expand the workforce. Establishes within the State Treasury, the Health Care Workforce Strategic Fund to contain funds from private, federal and state sources to be used to meet the goals of the Health Care Workforce Committee.</i>  Directs the Board to ensure that the health care workforce is sufficient in numbers and meets the demands that will be created by reform and changing demographics <i>and to oversee expenditures of moneys in the Funds.</i>	Creates a Health Care Workforce Cooperative to coordinate efforts to recruit and educate health care professionals and retain a quality workforce that meets the demands that will be created by reform and changing demographics.  Adopted the concepts of SB 457 to create and maintain a healthcare workforce database. Language is different from SB 457	Both versions created a Committee of the Board to address this issue.  Both versions intended to create and maintain a work force data base. The House version adopted SB 457 as passed by Senate Health. The Senate adopted the concept but slightly different language.  The House expands the duties of the Committee to include an inventory of grants and resources available in government to address this issue and oversee a Workforce Fund.
Insurance Market Reform	Senate: Section 18-20, pp. 11-14	N/A	The Board will work in consultation with DCBS to develop and approve one or more value-based health benefit plans that: promote the provision of PCPCH; impose minimal cost-sharing on evidence-based preventative care; create incentives for individuals to participate in their care; require greater contributions from enrollees for elective and discretionary services; include a defined set of services based on the prioritized list of health services; and comply with existing requirements. <i>All carriers offering products in the individual market will offer one or more plans based on the value-based benefit design, within 12 months of the benefit design's approval. Repeals the Health Insurance Reform Advisory Committee's authority to develop a basic benefits plan.</i>	Not sure if the language surrounding the development of a value-based benefit design in the Senate version is aligned with the intent. DCBS wants to be sure that the Authority and DCBS can within a short time frame, pass new requirements for the small and individual markets in terms of the benefits package that must be offered, without waiting for the process of the development of the value-based benefit design to be complete.

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Baseline Health Benefit Package	House: Section 9(1)(j), pp. 8; Section 16, pp. 11-12	<i>The Authority shall develop a baseline health benefits package to be used as the baseline for all health benefit plans offered through the Insurance Exchange. The package developed by the Authority shall: promote the provision of PCPCH; impose minimal cost-sharing on evidence-based preventative care; create incentives for individuals to participate in their care; require greater contributions from enrollees for elective and discretionary services; and include a defined set of services based on the prioritized list of health services.</i>		
New Small Group Product	House: Section 10(1)(L), pp. 9 Senate: Section 19a, pp. 12	The <i>Authority</i> is to develop, in consultation with DCBS, one or more products designed to provide more affordable options for the small group market.	The <i>Board</i> will work with DCBS in developing one or more products designed to provide more affordable options for the small group market.	
Health Insurance Exchange	House: Section 17b, pp. 12-13 Senate: Section 21, pp. 14	<p>The Authority, in consultation with DCBS, will develop a plan for staffing, funding and administration of the Health Insurance Exchange. A request to develop a measure will be submitted to <i>Legislative Council</i> no later than October 1, 2010.</p> <p>The plan will include: selection and pricing of benefit plans to be offered; the rating and underwriting standards applicable to the exchange, including whether to incorporate community rating or guaranteed issue; determining whether PEBB, OEBC and other public purchasers will offer coverage through the exchange; <i>development of a transition period for the rollover of individual policies into the exchange; enforcement of the rules governing the sale of insurance within the exchange; identifying the role of insurance providers; providing benefit plans through the exchange at little or no cost to low income individuals; maximizing the participation of private insurance plans offered through the exchange;</i> and determining how to ensure that employees of small employers and employees who are part-time or seasonal workers may access portability</p>	<p>The Board, in consultation with DCBS, will develop a detailed business and operational plan for the staffing, funding and administration of a Health Insurance Exchange. The plan will be delivered to the <i>correct interim committee of the Legislature</i> no later than October 1, 2010.</p> <p>The plan will include: selection and pricing of benefit plans to be offered; the rating and underwriting standards applicable to the exchange, including whether to incorporate community rating or guaranteed issue; determining whether PEBB, OEBC and other public purchasers will offer coverage through the exchange; <i>the development of a transition process for changes in coverage resulting from the creation of an exchange; establishing enrollment procedures and identifying the role of insurance providers;</i> determining whether the exchange will be the exclusive market for individuals or small group purchasers; determining whether and how employees of small employers and employees who are part-time or seasonal workers may access portability plans through the exchange; whether to incorporate and if so, how to incorporate,</p>	<ul style="list-style-type: none"> <li>• House Version directs the Board and DCBS to consider several different elements when developing a plan for an Exchange (HB 2009B, page 12, line 12). SB 856 says they "shall include all" the elements. (SB 856-8, page 24, line 19)</li> <li>• Senate Version doesn't include the following subsections from HB 2009B, Section 17b (1)(a): (E), (G), (H) and (1)(b): (A), (B), (C), (G).</li> </ul>

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		plans through the exchange. The Exchange MAY: establish criteria for the section of insurance carriers to participate in the exchange; determine whether the exchange will be the exclusive market for individuals or small group purchasers; determine whether and how to use health savings accounts, high deductible plans and Section 125 plans; and determine the need to develop and implement a reinsurance program.	health savings accounts, high deductible plans and Section 125 plans into the business plan.	
High Risk Pool	Senate: Section 22(1), pp. 14	N/A	<i>The Authority shall study and report to the 76th Legislative Assembly on recommendations for providing health insurance coverage to high-risk Oregonians. This shall include: whether to continue using the Oregon Medical Insurance Pool(OMIP) to provide high-risk coverage; what additional options should be made available and how they should be funded; and options that utilize reinsurance or other mechanisms to spread risk and stabilize pricing in the individual and small group markets. If the Authority concludes OMIP should not be continued, it should develop a transition plan to move individuals covered in OMIP to other coverage.</i>	
Publicly-Owned Health Benefit Plan	House: Section 9(1)(L), pp. 8 Senate: Section 22(2), pp. 15	The Authority shall develop a plan to submit to the Legislature by December 31, 2010 for the development of a publicly-owned benefit plan <i>that operates within the Exchange.</i>	The Board shall make recommendations to the 76th Legislative Assembly with regarding a publicly-owned option.	House version assumes the publicly-owned will operate only within the exchange.  Senate version assumes a publicly-owned plan that can operate in the private market arena as well as the Exchange.
Individual Mandate	House: Section (9)(1)(m)(A) Senate: Section 22(3), pp. 15	The Board duties is to study and report the Legislative Assembly by December 31, 2010 and annually thereafter about the feasibility and advisability of implementing a requirement that ever resident have health insurance coverage.	The Board shall study and report to the 76th Legislative Assembly with recommendation regarding the feasibility and advisability of a requirement that every Oregon resident obtain and maintain insurance coverage.	
Payroll Tax	House: Section (9)(1)(m)(B), pp. 8	<i>The Board shall study and report to the Legislative Assembly by December 31, 2010 and annually thereafter about the feasibility and advisability of using a payroll tax as a means to encourage employers to continue providing health insurance to their employees.</i>	N/A	

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Premium Assistance	House: Section 9(1)(c), pp. 7, Section 9(1)(m)(c), pp. 8 Senate: Section 18(2), pp. 11	The Board duties is to <i>develop</i> a program to provide health insurance premium assistance to low and moderate income individuals who are legal residents of the state. <i>The Board is also to study and report to the Legislative Assembly by December 31, 2010 and annually thereafter about the feasibility and advisability of expanding the health insurance exchange to include a program of premium assistance.</i>	The Authority Board shall <i>implement</i> a program to provide health insurance premium assistance to low and moderate income residents.	Senate version has drafting error. The intent of the Senate version was to have the Authority develop, not actually implement, a premium assistance program.
Three-Share Coverage Programs	House: Section 10(1)(k), pp. 9 Senate: Section 22(4), pp. 15	<i>The Board is to guide and support community three-share agreements.</i>	<i>The Board shall report to the 76th Legislative Assembly about opportunities to expand coverage by developing and establishing pilot projects implementing three share coverage programs.</i>	Language in House version will give state more flexibility in supporting community multi-share programs.
Payment Reform	House: Section 9(1)(n), pp. 8; Section 10(1)(j), pp. 9 Senate: Section 22(5), pp. 15	<i>The Board shall meet cost-containment goals by structuring reimbursement rates to reward comprehensive management of disease, quality outcomes and the efficient use of resources. Included in Authority duties to structure reimbursement to meet these goals.</i>	<i>The Board shall report to the 76th Legislative Assembly (by December 31, 2010) about opportunities to utilize the payment system and payment reform as a tool to create incentives in health care to provide high quality care.</i>	
Malpractice Liability System Reform	Senate: Section 22(6), pp. 15	N/A	The Board shall report to the 76th Legislative Assembly about opportunities to reform the malpractice liability system in Oregon.	
Health Care Data Reporting	House: Section 1200-1203, pp. 587-589 Senate: Section 32-35, pp. 18-21	Requires <i>OHPR</i> to establishes an all-payer, all-claims data reporting program. Adopted language contained in SB 453 as passed by Senate Health.	Requires the <i>Authority</i> to establishes an all-payer, all-claims data reporting program. Adopted the concept of SB 453 as passed by Senate Health but the language is different.	Both houses intended to adopt the provisions of SB 453 as passed by Senate Health. The Senate version is missing some language around gender, ethnicity and size of sample. Appears that the -1 amendments to SB 453 were missed and they are part of the engrossed version. Because the House adopted SB 453 as passed the duties are assigned to OHPR while the Senate assigns the duties to the Authority. Probably should be OHPR.
Health Information Technology (HIT)	House: Section 1167-1173, pp. 576-578 Senate: Section 7(4)(a), pp. 5	Adopted the provisions of SB 452 as passed by Senate Health creating a HIT oversight Council and specifying duties.	Adopted concept of SB 452 as passed by Senate Health creating an HIT oversight Council and specifying duties.	House adopted SB 452 as passed by Senate Health. Senate intended to adopt same language but only adopted the duties of the Council, not the appointment process, or the definitions necessary to implement language.
Patient-Centered Primary Care Homes (PCPCH)	House: Section 1163-1165, p. 574-575 Senate: Section 9, pp. 6-8	Adopted provisions of SB 456 as passed by Senate Health.	Senate adopted concept but not the language of SB 456.	House version adopted SB 456 as passed by Senate Health. In doing so gave the duties to OHPR instead of the Board. May wish to correct that.

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Evidence-Based Medicine	House: Section 1179-1180, pp. 580-581 Senate: Section 11, pp. 8-9	House adopted the provisions of SB 455	Senate adopted concept of SB 455 but <i>added a charge to the Quality Care Institute to develop uniform quality performance standards. The language does not require use of these standards by the Department of corrections.</i>	Both versions desire evidence-based quality standards. Both adopted the concept of SB 455 but the Senate language is slightly different
Uniform Contracting	House: Section 10(2)(b), pp. 10; Section 1179(4), pp. 581 Senate: Section 11(6), pp. 9	<i>The Board and the Authority are authorized to develop uniform contracting standards for the purchase of health care including: uniform quality performance standards, evidence-based guidelines, evidence-based effectiveness, guidelines for new technologies and medical equipment and a statewide drug formulary.</i>	The Public Employers Health Cooperative shall pursue uniform contract and purchasing standards.	Both bills attempt to address same issue by adopting SB 455.  House develops standards for all but mandates use of standards for PEBB/OEB.
Uniform Standards for Health Insurers	House, Section 1191-1193, pp. 584 Senate: Section 14, pp. 10-11	Adopted the provisions of SB 454	Adopted the provisions of SB 454.	Since the HFB policy bills were copied directly into House version, programs were assigned to OHPR that should come under the authority of the Authority. Probably requires some clean up.
Health Insurance Reporting	House: Section 1195, pp. 584 Senate: Section 15-17, pp. 11	Health insurers and TPAs will be required to report to DCBS annually on the number of covered lives, reported by line of business and zip code. DCBS shall aggregate this data and may publish aggregated data.	Health insurers and TPAs will be required to report to DCBS annually on the number of covered lives, reported by line of business and zip code. DCBS shall aggregate this data and may publish aggregated data.	Both houses adopted this portion of SB 454 as passed by Senate Health
Capital Project Reporting	House: Section 1196-1199, pp. 585-586	Adopted provisions of SB 454 on capital project reporting. Defines capital project that are subject to reporting requirements. Allows OHPR to establish rules requiring reporting entitles to publicly report proposed capitol project on their website and or in newspapers and to allow for public comment. Allows OHPR to administer civil penalties on entities that do not fulfill reporting requirements.	N/A	House language is part of SB 454
Registry of Physician Orders for Life-sustaining Treatment (POLST)	House: Sections 1181-1190, pp. 581-584 Senate: Section 36-44, pp. 21-23	Establishes a POLST. Adopted language contained in SB 451 as passed by Senate Health.	Establishes a POLST. Adopted language contained in SB 451 as passed by Senate Health.	

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 Except where noted, House column refers to HB 2009B and Senate column refers to SB 856A

Subject Area	Section and Page	House Version	Senate Version	Comments
Insurance Rate Review	House: Section 10(1)(i), pp. 9 Senate: Section 52a-52d, pp. 27-28	<i>The duties of the Authority include working with DCBS to propose recommended standards and methodologies to the 76th Legislative Assembly for review of administrative expenses of health insurers, approval of rates, and enforcement of rating rules.</i>	<i>Requires DCBS to open a 30-day public comment period when an insurer files a schedule or table of premium rates for individual or small group insurance. Allows DCBS to only collect public comments on rating standards and factors and administrative expenses and requires DCBS to post all comments on its website. Requires DCBS to give written notice to an insurer approving or disapproving a rate filing. Requires all insurers to include in rate filing reports a statement of administrative expenses on a per member per month basis and an explanation of the basis for proposed increases. Allows the director of DCBS to specify information required in a rate filing and determine information that will be exempt from disclosure. The director may approve the premium rate if it is actuarially sound, reasonable and not excessive, inadequate or unfairly discriminatory (determination of which may include insurer's financial position, historical and projected administrative costs and loss ratios, anticipated change in the number of enrollees, changes to benefits, changes to cost containment and quality improvement efforts, whether the change is necessary to maintain solvency, a positive sound allowance for a contribution to surplus and public comments) and based on reasonable administrative</i>	DCBS has concerns over the rate review standards established in the Senate version. It appears the language in Subsection 52d(6)(h) would prevent either DCBS or the insurer from using excess surplus to moderate rate increases [line 11 on page 50 "may not be less than zero" is the problematic language]. DCBS suggests modifying the language to make it clear that rate increases can be moderated by using excess surplus. Subsection (6)(h) could simply be modified to make it clear that contributions could be made to surplus or surplus could be used to moderate rate increases. Alternatively, Subsection (6)(h) could simply be deleted. In addition, DCBS states that ORS 743.018(3) must be deleted in order to give effect to the rulemaking proposed in the new (4) [delete lines 1-7 on page 49 of the Senate version].
TPAs	Senate: Section 52, pp. 25-26	N/A	Removes the exemption from third party administrator licensure requirements for administrators for one or more employee benefit plans.	
Emergency Clause	House: Section 1206, pp. 589 Senate: Section 79, pp. 60	Declares emergency, effective on passage.	Declares emergency, effective on passage	