# A-Engrossed
# House Bill 2391

Ordered by the House June 13
Including House Amendments dated June 13

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of House Interim Committee on Health Care)

## 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.

[*Requires Oregon Health Authority to submit blueprint for basic health plan to Centers for Medicare and Medicaid Services by December 31, 2017.*]

**Imposes 1.5 percent assessment on commercial health insurance premiums and premium equivalents for managed care organizations and Public Employees' Benefit Board health benefit plans. Requires assessments to be credited to Health System Fund to pay for Oregon Reinsurance Program, state medical assistance and costs associated with administering assessments.**

**Establishes Oregon Reinsurance Program in Department of Consumer and Business Services to stabilize rates and premiums for individual health benefit plans and provide greater financial certainty to health insurance consumers. Requires department to apply for federal waiver to carry out program.**

**Modifies hospital assessment by making type A hospitals and type B hospitals subject to assessment and excluding public hospitals other than health district hospitals. Authorizes Oregon Health Authority to impose lower rate of assessment on type A hospitals and type B hospitals. Expands permitted uses of funds in Hospital Quality Assurance Fund. Requires authority to apply for federal approval to modify hospital assessment.**

**Requires Oregon Health Authority to ensure specified level of reimbursement for costs of Oregon Health and Science University in providing services paid for with Medicaid funds.**

**Transfers moneys from specified funds and accounts in State Treasury to Health System Fund.**

[*Declares emergency, effective on passage.*]

**Takes effect on 91st day following adjournment sine die.**

## A BILL FOR AN ACT

Relating to access to health care; creating new provisions; amending ORS 291.055, 731.292, 731.509 and 731.840 and sections 1, 2, 3, 5, 7, 9, 10, 12, 13 and 14, chapter 736, Oregon Laws 2003, and section 2, chapter 26, Oregon Laws 2016; repealing section 15, chapter 389, Oregon Laws 2015; prescribing an effective date; and providing for revenue raising that requires approval by a three-fifths majority.

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

## HEALTH INSURANCE PREMIUM AND MANAGED CARE ASSESSMENT

**SECTION 1. Sections 2 to 8 of this 2017 Act are added to and made a part of the Insurance Code.**

**SECTION 2. (1) The Health System Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Health System Fund shall be credited to the fund.**

**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.

**(2) Amounts in the Health System Fund are continuously appropriated to the Department of Consumer and Business Services for the purposes of:**

**(a) Administering the Oregon Reinsurance Program established in section 18 of this 2017 Act; and**

**(b) Transferring moneys to the Oregon Health Authority to:**

**(A) Provide medical assistance and other health services under ORS chapter 414.**

**(B) Pay refunds due under section 11 of this 2017 Act.**

**(C) Pay administrative costs incurred by the authority to administer the assessment described in section 9 of this 2017 Act.**

**SECTION 3. (1) As used in this section:**

**(a) "Insured" means an eligible employee or family member, as defined in ORS 243.105, who is enrolled in a self-insured health benefit plan under ORS 243.105 to 243.285.**

**(b) "Premium equivalent" means a claim for reimbursement of the cost of a health care item or service provided to an eligible employee or family member, other than a dental or vision care item or service, and the administrative costs associated with the claim.**

**(2) No later than 45 days following the end of a calendar quarter, the Public Employees' Benefit Board shall pay an assessment at the rate of 1.5 percent on the gross amount of premium equivalents received during the calendar quarter.**

**(3) The assessment shall be paid to the Department of Consumer and Business Services and shall be accompanied by a verified report, on a form prescribed by the department, together with any information required by the department.**

**(4) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on the board.**

**(5) If the department determines that the assessment paid by the board under this section is incorrect, the department shall charge or credit to the board the difference between the correct amount of the assessment and the amount paid by the board.**

**(6) The board is entitled to notice and an opportunity for a contested case hearing under ORS chapter 183 to contest an action of the department taken pursuant to subsection (5) of this section.**

**(7) Moneys received by the department under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act.**

**SECTION 4. Section 3 of this 2017 Act applies to premium equivalents received by the Public Employees' Benefit Board, or a third party administrator that contracts with the board to administer a self-insured health benefit plan, during the period from January 1, 2018, through December 31, 2019.**

**SECTION 5. (1) As used in this section:**

**(a) "Gross amount of premiums" has the meaning given that term in ORS 731.808.**

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

**(2) No later than 45 days following the end of a calendar quarter, an insurer shall pay an assessment at the rate of 1.5 percent of the gross amount of premiums earned by the insurer during that calendar quarter that were derived from health benefit plans delivered or issued for delivery in Oregon.**

**(3) The assessment shall be paid to the Department of Consumer and Business Services and shall be accompanied by a verified form prescribed by the department together with any**

**information required by the department, that reports:**

**(a) All health benefit plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid; and**

**(b) The gross amount of premiums by line of insurance, derived by the insurer from all health benefit plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid.**

**(4) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on an insurer.**

**(5) Any rate filed for the department's approval may include amounts paid by the insurer under this section as a valid element of administrative expense or retention.**

**(6) Moneys received by the department under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act.**

**SECTION 6. (1) If the Public Employees' Benefit Board or an insurer fails to timely file a verified form or to pay an assessment required under section 3 or 5 of this 2017 Act, the Department of Consumer and Business Services shall impose a penalty on the board or insurer of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.**

**(2) Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under sections 3 and 5 of this 2017 Act.**

**SECTION 7. (1) If the Department of Consumer and Business Services determines that the assessment paid by the insurer under section 5 of this 2017 Act is incorrect, the department shall charge or credit to the insurer the difference between the correct amount of the assessment and the amount paid by the insurer.**

**(2) An insurer that is aggrieved by an action of the department taken pursuant to subsection (1) of this section shall be entitled to notice and an opportunity for a contested case hearing under ORS chapter 183.**

**SECTION 8. (1) Section 5 of this 2017 Act applies to premiums earned by an insurer for a period of eight calendar quarters beginning on the date, on or after January 1, 2018, that the policy or certificate for which the premiums are paid is issued or renewed.**

**(2) Notwithstanding any provision of contract or statute, including ORS 743B.013 and 743.022, insurers may increase their premium rate on policies or certificates that are subject to the assessment under section 5 of this 2017 Act by 1.5 percent. If an insurer increases its rates under this subsection, the insurer may include in its billings for health benefit plans a notice, as prescribed by the Department of Consumer and Business Services, explaining that the increase is due to the assessment under section 5 of this 2017 Act.**

**SECTION 9. (1) As used in this section and sections 10 and 11 of this 2017 Act:**

**(a) "Managed care organization" means:**

**(A) A coordinated care organization as defined in ORS 414.025; and**

**(B) A prepaid managed care health services organization as defined in ORS 414.025.**

**(b) "Premium equivalent" means the payments made to the managed care organization by the Oregon Health Authority for providing health services under ORS chapter 414.**

**(2) No later than 45 days following the end of a calendar quarter, a managed care organization shall pay an assessment at a rate of 1.5 percent of the gross amount of premium**

**equivalents received during that calendar quarter.**

**(3) The assessment shall be paid to the authority in a manner and form prescribed by the authority.**

**(4) Assessments received by the authority under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act.**

**(5) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on a managed care organization.**

**SECTION 10. (1) If a managed care organization fails to timely pay an assessment under section 9 of this 2017 Act, the Oregon Health Authority shall impose a penalty on the managed care organization of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.**

**(2) Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under section 9 of this 2017 Act.**

**(3) Penalties received by the authority under this section shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act.**

**SECTION 11. (1) A managed care organization that has paid an amount that is not required under section 9 of this 2017 Act may file a claim for refund with the Oregon Health Authority.**

**(2) Any managed care organization that is aggrieved by an action of the authority taken pursuant to subsection (1) of this section shall be entitled to notice and an opportunity for a contested case hearing under ORS chapter 183.**

**SECTION 12. Sections 9, 10 and 11 of this 2017 Act apply to any payments made to a managed care organization by the Oregon Health Authority for the period beginning January 1, 2018, and ending December 31, 2019.**

**SECTION 13.** ORS 731.292 is amended to read:

731.292. (1) Except as provided in subsections (2)**,** [*and*] (3) **and (4)** of this section, all fees, charges and other moneys received by the Department of Consumer and Business Services or the Director of the Department of Consumer and Business Services under the Insurance Code shall be deposited in the fund created by ORS 705.145 and are continuously appropriated to the department for the payment of the expenses of the department in carrying out the Insurance Code.

(2) All taxes and penalties paid pursuant to the Insurance Code shall be paid to the director and after deductions of refunds shall be paid by the director to the State Treasurer, at the end of every calendar month or more often in the director's discretion, for deposit in the General Fund to become available for general governmental expenses.

(3) All premium taxes received by the director pursuant to ORS 731.820 shall be paid by the director to the State Treasurer for deposit in the State Fire Marshal Fund.

**(4) Assessments received by the department under sections 3 and 5 of this 2017 Act and penalties received by the department under section 6 of this 2017 Act shall be paid into the State Treasury and credited to the Health System Fund established under section 2 of this 2017 Act.**

**SECTION 14.** ORS 731.840 is amended to read:

731.840. (1) The retaliatory tax imposed upon a foreign or alien insurer under ORS 731.854 and

731.859, or the corporate excise tax imposed upon a foreign or alien insurer under ORS chapter 317, is in lieu of all other state taxes upon premiums, taxes upon income, franchise or other taxes measured by income that might otherwise be imposed upon the foreign or alien insurer except the fire insurance premiums tax imposed under ORS 731.820**,** [*and*] the tax imposed upon wet marine and transportation insurers under ORS 731.824 and 731.828 **and the assessment imposed under section 5 of this 2017 Act**. However, all real and personal property, if any, of the insurer shall be listed, assessed and taxed the same as real and personal property of like character of noninsurers. Nothing in this subsection shall be construed to preclude the imposition of the assessments imposed under ORS 656.612 upon a foreign or alien insurer.

(2) Subsection (1) of this section applies to a reciprocal insurer and its attorney in its capacity as such.

(3) Subsection (1) of this section applies to foreign or alien title insurers and to foreign or alien wet marine and transportation insurers issuing policies and subject to taxes referred to in ORS 731.824 and 731.828.

(4) The State of Oregon hereby preempts the field of regulating or of imposing excise, privilege, franchise, income, license, permit, registration, and similar taxes, licenses and fees upon insurers and their insurance producers and other representatives as such, and:

(a) No county, city, district, or other political subdivision or agency in this state shall so regulate, or shall levy upon insurers, or upon their insurance producers and representatives as such, any such tax, license or fee; except that whenever a county, city, district or other political subdivision levies or imposes generally on a nondiscriminatory basis throughout the jurisdiction of the taxing authority a payroll, excise or income tax, as otherwise provided by law, such tax may be levied or imposed upon domestic insurers; and

(b) No county, city, district, political subdivision or agency in this state shall require of any insurer, insurance producer or representative, duly authorized or licensed as such under the Insurance Code, any additional authorization, license, or permit of any kind for conducting therein transactions otherwise lawful under the authority or license granted under this code.

**SECTION 15.** ORS 291.055 is amended to read:

291.055. (1) Notwithstanding any other law that grants to a state agency the authority to establish fees, all new state agency fees or fee increases adopted during the period beginning on the date of adjournment sine die of a regular session of the Legislative Assembly and ending on the date of adjournment sine die of the next regular session of the Legislative Assembly:

(a) Are not effective for agencies in the executive department of government unless approved in writing by the Director of the Oregon Department of Administrative Services;

(b) Are not effective for agencies in the judicial department of government unless approved in writing by the Chief Justice of the Supreme Court;

(c) Are not effective for agencies in the legislative department of government unless approved in writing by the President of the Senate and the Speaker of the House of Representatives;

(d) Shall be reported by the state agency to the Oregon Department of Administrative Services within 10 days of their adoption; and

(e) Are rescinded on adjournment sine die of the next regular session of the Legislative Assembly as described in this subsection, unless otherwise authorized by enabling legislation setting forth the approved fees.

(2) This section does not apply to:

(a) Any tuition or fees charged by a public university listed in ORS 352.002.

(b) Taxes or other payments made or collected from employers for unemployment insurance required by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

(A) Health care services provided by the Oregon Health and Science University, by the Oregon Veterans' Homes and by other state agencies and institutions pursuant to ORS 179.610 to 179.770.

(B) Assessments imposed by the Oregon Medical Insurance Pool Board under section 2, chapter 698, Oregon Laws 2013.

(C) Copayments and premiums paid to the Oregon medical assistance program.

**(D) Assessments paid to the Department of Consumer and Business Services under sections 3 and 5 of this 2017 Act.**

(d) Fees created or authorized by statute that have no established rate or amount but are calculated for each separate instance for each fee payer and are based on actual cost of services provided.

(e) State agency charges on employees for benefits and services.

(f) Any intergovernmental charges.

(g) Forest protection district assessment rates established by ORS 477.210 to 477.265 and the Oregon Forest Land Protection Fund fees established by ORS 477.760.

(h) State Department of Energy assessments required by ORS 469.421 (8) and 469.681.

(i) Assessments on premiums charged by the Department of Consumer and Business Services pursuant to ORS 731.804 or fees charged by the Division of Finance and Corporate Securities of the Department of Consumer and Business Services to banks, trusts and credit unions pursuant to ORS 706.530 and 723.114.

(j) Public Utility Commission operating assessments required by ORS 756.310 or charges paid to the Residential Service Protection Fund required by chapter 290, Oregon Laws 1987.

(k) Fees charged by the Housing and Community Services Department for intellectual property pursuant to ORS 456.562.

(L) New or increased fees that are anticipated in the legislative budgeting process for an agency, revenues from which are included, explicitly or implicitly, in the legislatively adopted budget or the legislatively approved budget for the agency.

(m) Tolls approved by the Oregon Transportation Commission pursuant to ORS 383.004.

(n) Convenience fees as defined in ORS 182.126 and established by the State Chief Information Officer under ORS 182.132 (3) and recommended by the Electronic Government Portal Advisory Board.

(3)(a) Fees temporarily decreased for competitive or promotional reasons or because of unexpected and temporary revenue surpluses may be increased to not more than their prior level without compliance with subsection (1) of this section if, at the time the fee is decreased, the state agency specifies the following:

(A) The reason for the fee decrease; and

(B) The conditions under which the fee will be increased to not more than its prior level.

(b) Fees that are decreased for reasons other than those described in paragraph (a) of this subsection may not be subsequently increased except as allowed by ORS 291.050 to 291.060 and 294.160.

**SECTION 16.** ORS 291.055, as amended by section 36, chapter 698, Oregon Laws 2013, section 20, chapter 70, Oregon Laws 2015, and section 44b, chapter 807, Oregon Laws 2015, is amended to

read:

291.055. (1) Notwithstanding any other law that grants to a state agency the authority to establish fees, all new state agency fees or fee increases adopted during the period beginning on the date of adjournment sine die of a regular session of the Legislative Assembly and ending on the date of adjournment sine die of the next regular session of the Legislative Assembly:

(a) Are not effective for agencies in the executive department of government unless approved in writing by the Director of the Oregon Department of Administrative Services;

(b) Are not effective for agencies in the judicial department of government unless approved in writing by the Chief Justice of the Supreme Court;

(c) Are not effective for agencies in the legislative department of government unless approved in writing by the President of the Senate and the Speaker of the House of Representatives;

(d) Shall be reported by the state agency to the Oregon Department of Administrative Services within 10 days of their adoption; and

(e) Are rescinded on adjournment sine die of the next regular session of the Legislative Assembly as described in this subsection, unless otherwise authorized by enabling legislation setting forth the approved fees.

(2) This section does not apply to:

(a) Any tuition or fees charged by a public university listed in ORS 352.002.

(b) Taxes or other payments made or collected from employers for unemployment insurance required by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

(A) Health care services provided by the Oregon Health and Science University, by the Oregon Veterans' Homes and by other state agencies and institutions pursuant to ORS 179.610 to 179.770.

(B) Copayments and premiums paid to the Oregon medical assistance program.

**(C) Assessments paid to the Department of Consumer and Business Services under sections 3 and 5 of this 2017 Act.**

(d) Fees created or authorized by statute that have no established rate or amount but are calculated for each separate instance for each fee payer and are based on actual cost of services provided.

(e) State agency charges on employees for benefits and services.

(f) Any intergovernmental charges.

(g) Forest protection district assessment rates established by ORS 477.210 to 477.265 and the Oregon Forest Land Protection Fund fees established by ORS 477.760.

(h) State Department of Energy assessments required by ORS 469.421 (8) and 469.681.

(i) Assessments on premiums charged by the Department of Consumer and Business Services pursuant to ORS 731.804 or fees charged by the Division of Finance and Corporate Securities of the Department of Consumer and Business Services to banks, trusts and credit unions pursuant to ORS 706.530 and 723.114.

(j) Public Utility Commission operating assessments required by ORS 756.310 or charges paid to the Residential Service Protection Fund required by chapter 290, Oregon Laws 1987.

(k) Fees charged by the Housing and Community Services Department for intellectual property pursuant to ORS 456.562.

(L) New or increased fees that are anticipated in the legislative budgeting process for an

agency, revenues from which are included, explicitly or implicitly, in the legislatively adopted budget or the legislatively approved budget for the agency.

(m) Tolls approved by the Oregon Transportation Commission pursuant to ORS 383.004.

(n) Convenience fees as defined in ORS 182.126 and established by the State Chief Information Officer under ORS 182.132 (3) and recommended by the Electronic Government Portal Advisory Board.

(3)(a) Fees temporarily decreased for competitive or promotional reasons or because of unexpected and temporary revenue surpluses may be increased to not more than their prior level without compliance with subsection (1) of this section if, at the time the fee is decreased, the state agency specifies the following:

(A) The reason for the fee decrease; and

(B) The conditions under which the fee will be increased to not more than its prior level.

(b) Fees that are decreased for reasons other than those described in paragraph (a) of this subsection may not be subsequently increased except as allowed by ORS 291.050 to 291.060 and 294.160.

**OREGON REINSURANCE PROGRAM**

**SECTION 17. Sections 18 to 21 of this 2017 Act are added to and made a part of the Insurance Code.**

**SECTION 18. The Oregon Reinsurance Program is established in the Department of Consumer and Business Services for the purposes of stabilizing the rates and premiums for individual health benefit plans and providing greater financial certainty to consumers of health insurance in this state.**

**SECTION 19. (1) As used in this section:**

**(a) "Attachment point" means the threshold dollar amount, adopted by the Department of Consumer and Business Services by rule, for claims costs incurred by a reinsurance eligible health benefit plan for an insured individual's covered benefits in a benefit year, after which threshold the claims costs for the benefits are eligible for reinsurance payments.**

**(b) "Coinsurance rate" means the rate, adopted by the department by rule, at which the department will reimburse a reinsurance eligible health benefit plan for claims costs incurred for an insured individual's covered benefits in a benefit year after the attachment point and before the reinsurance cap.**

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

**(d) "Reinsurance cap" means the threshold dollar amount, adopted by the department by rule, for claims costs incurred by a reinsurance eligible health benefit plan for an insured individual's covered benefits in a benefit year, after which threshold the claims costs for the benefits are no longer eligible for state reinsurance payments.**

**(e) "Reinsurance eligible health benefit plan" means a health benefit plan providing individual coverage that:**

**(A) Is delivered or issued for delivery in this state; and**

**(B) Is not a grandfathered health plan as defined in ORS 743B.005.**

**(f) "Reinsurance eligible individual" means an individual who is insured in a reinsurance eligible health benefit plan on or after January 1, 2018.**

**(2) An issuer of a reinsurance eligible health benefit plan becomes eligible for a reinsurance payment when the claims costs for a reinsurance eligible individual's covered benefits**

**in a calendar year exceed the attachment point. The amount of the payment shall be the product of the coinsurance rate and the issuer's claims costs for the reinsurance eligible individual that exceed the attachment point, up to the reinsurance cap.**

**(3) After the department adopts by rule the attachment point, reinsurance cap or coinsurance rate, the department may not:**

**(a) Change the attachment point or the reinsurance cap during that benefit year; or**

**(b) Increase the coinsurance rate during the benefit year.**

**(4) The department may adopt rules necessary to carry out the provisions of this section including, but not limited to, rules prescribing:**

**(a) The amount, manner and frequency of reinsurance payments; and**

**(b) Reporting requirements for issuers of reinsurance eligible health benefit plans.**

**SECTION 20. (1) As used in this section:**

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

**(b) "Oregon Reinsurance Program" means the program established in section 18 of this 2017 Act.**

**(c) "Reinsurance eligible individual" has the meaning given that term in section 19 of this 2017 Act.**

**(2) An insurer that offers a health benefit plan must report to the Department of Consumer and Business Services, in the form and manner prescribed by the department by rule, information about reinsurance eligible individuals insured by the health benefit plan as necessary for the department to calculate reinsurance payments under the Oregon Reinsurance Program.**

**SECTION 21. In a rate filing under ORS 743.018, an insurer must identify the impact of reinsurance payments under section 19 of this 2017 Act on projected claims costs and in the development of rates.**

**SECTION 22. The Oregon Reinsurance Program established in section 18 of this 2017 Act shall be exempt from any and all taxes assessed by the State of Oregon.**

**SECTION 23.** ORS 731.509, as amended by section 35, chapter 698, Oregon Laws 2013, is amended to read:

731.509. (1) The purpose of ORS 731.509, 731.510, 731.511, 731.512 and 731.516 is to protect the interests of insureds, claimants, ceding insurers, assuming insurers and the public generally. The Legislative Assembly declares that its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislative Assembly mandates that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations in accordance with ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurers. The Legislative Assembly declares that the laws contained in ORS 731.509, 731.510, 731.511, 731.512 and 731.516 are fundamental to the business of insurance in accordance with 15 U.S.C. 1011 and 1012.

(2) The Director of the Department of Consumer and Business Services shall not allow credit for reinsurance to a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded unless credit is allowed as provided under ORS 731.508 and unless the re-

insurer meets the requirements of:

(a) Subsection (3) of this section;

(b) Subsection (4) of this section;

(c) Subsections (5) and (8) of this section;

(d) Subsections (6) and (8) of this section; [*or*]

(e) Subsection (7) of this section[.]**; or**

**(f) Subsection (9) of this section.**

(3) Credit shall be allowed when the reinsurance is ceded to an authorized assuming insurer that accepts reinsurance of risks, and retains risk thereon within such limits, as the assuming insurer is otherwise authorized to insure in this state as provided in ORS 731.508.

(4) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state as provided in ORS 731.511. The director shall not allow credit to a domestic ceding insurer if the accreditation of the assuming insurer has been revoked by the director after notice and opportunity for hearing.

(5) Credit shall be allowed when the reinsurance is ceded to a foreign assuming insurer or a United States branch of an alien assuming insurer meeting all of the following requirements:

(a) The foreign assuming insurer must be domiciled in a state employing standards regarding credit for reinsurance that equal or exceed the standards applicable under this section. The United States branch of an alien assuming insurer must be entered through a state employing such standards.

(b) The foreign assuming insurer or United States branch of an alien assuming insurer must maintain a combined capital and surplus in an amount not less than $20,000,000. The requirement of this paragraph does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(c) The foreign assuming insurer or United States branch of an alien assuming insurer must submit to the authority of the director to examine its books and records.

(6) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund meeting the requirements of this subsection and additionally complies with other requirements of this subsection. The trust fund must be maintained in a qualified United States financial institution, as defined in ORS 731.510 (1), for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer must report annually to the director information substantially the same as that required to be reported on the annual statement form by ORS 731.574 by authorized insurers, in order to enable the director to determine the sufficiency of the trust fund. The following requirements apply to such a trust fund:

(a) In the case of a single assuming insurer, the trust fund must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers. In addition, the assuming insurer must maintain a trusteed surplus of not less than $20,000,000.

(b) In the case of a group including incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group.

(B) For reinsurance ceded under reinsurance agreements with an inception date on or before

July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the trust shall consist of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States.

(C) In addition to the trusts described in subparagraphs (A) and (B) of this paragraph, the group shall maintain in trust a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(D) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(E) Within 90 days after the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if certification is unavailable, financial statements of each underwriter member of the group prepared by independent certified public accountants.

(c) In the case of a group of incorporated insurers described in this paragraph, the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group. This paragraph applies to a group of incorporated insurers under common administration that complies with the annual reporting requirements contained in this subsection and that has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation. Such a group must have an aggregate policyholders' surplus of $10,000,000,000 and must submit to the authority of this state to examine its books and records and bear the expense of the examination. The group shall also maintain a joint trusteed surplus of which $100,000,000 must be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities. Each member of the group shall make available to the director an annual certification of the member's solvency by the member's domiciliary regulator and its independent certified public accountant.

(d) The form of the trust and any amendment to the trust shall have been approved by the insurance commissioner of the state in which the trust is domiciled or by the insurance commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(e) The form of the trust and any trust amendments also shall be filed with the insurance commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the director. The trust must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(f) Not later than March 1 of each year, the trustees of each trust shall report to the director in writing the balance of the trust and listing the trust's investments at the preceding year end, and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31.

(7) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting

the requirements of subsection (3), (4), (5) or (6) of this section, but only as to the insurance of risks located in jurisdictions in which the reinsurance is required by applicable law or regulation of that jurisdiction.

(8) If the assuming insurer is not authorized to transact insurance in this state or accredited as a reinsurer in this state, the director shall not allow the credit permitted by subsections (5) and (6) of this section unless the assuming insurer agrees in the reinsurance agreement to the provisions stated in this subsection. This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement. The assuming insurer must agree in the reinsurance agreement:

(a) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(b) To designate the director or a designated attorney as its true and lawful attorney upon whom any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company may be served.

**(9) Credit shall be allowed when the reinsurance is ceded to the Oregon Reinsurance Program established in section 18 of this 2017 Act.**

[*(9)*] **(10)** If the assuming insurer does not meet the requirements of subsection (3), (4) or (5) of this section, the credit permitted by subsection (6) of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the applicable amount required by subsection (6)(a), (b) or (c) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of the grantor's state or country of domicile, the trustee shall comply with an order of the insurance commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance commissioner with regulatory oversight all the assets of the trust fund.

(b) The assets shall be distributed by and claims shall be filed with and valued by the insurance commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

(c) If the insurance commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the insurance commissioner according to the laws of that state and according to the terms of the trust agreement not inconsistent with the laws of that state.

(d) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this subsection.

**SECTION 24.** Section 2, chapter 26, Oregon Laws 2016, is amended to read:

**Sec. 2.** [*(1) Subject to subsection (2) of this section,*] The Department of Consumer and Business Services shall have sole authority to apply for a waiver for state innovation under 42 U.S.C. 18052. [*In developing an application for a waiver, the department shall convene an advisory group to advise and assist the department in identifying federal provisions subject to waiver that are expected to im-*

*prove the delivery of quality health care to residents of this state including, but not limited to, alternative approaches for achieving the objectives of the Basic Health Program as described in section 1 (4) of this 2016 Act.*] **The department shall apply for a waiver to receive funding to implement the Oregon Reinsurance Program established in section 18 of this 2017 Act.**

[*(2) The department may not submit an application for a waiver to the United States Secretary of Health and Human Services or Secretary of the Treasury until the department has presented the proposed application for a waiver to the committees of the Legislative Assembly related to health and to the Legislative Assembly as specified in subsection (3) of this section.*]

[*(3) Not later than March 1, 2017, the department shall report to the Legislative Assembly, in the manner provided in ORS 192.245, its recommendations for submitting an application for a waiver under 42 U.S.C. 18052.*]

**SECTION 25.** ORS 731.509, as amended by section 35, chapter 698, Oregon Laws 2013, and section 23 of this 2017 Act, is amended to read:

731.509. (1) The purpose of ORS 731.509, 731.510, 731.511, 731.512 and 731.516 is to protect the interests of insureds, claimants, ceding insurers, assuming insurers and the public generally. The Legislative Assembly declares that its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislative Assembly mandates that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations in accordance with ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurers. The Legislative Assembly declares that the laws contained in ORS 731.509, 731.510, 731.511, 731.512 and 731.516 are fundamental to the business of insurance in accordance with 15 U.S.C. 1011 and 1012.

(2) The Director of the Department of Consumer and Business Services shall not allow credit for reinsurance to a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded unless credit is allowed as provided under ORS 731.508 and unless the reinsurer meets the requirements of:

(a) Subsection (3) of this section;

(b) Subsection (4) of this section;

(c) Subsections (5) and (8) of this section;

(d) Subsections (6) and (8) of this section; **or**

(e) Subsection (7) of this section.[*; or*]

[*(f) Subsection (9) of this section.*]

(3) Credit shall be allowed when the reinsurance is ceded to an authorized assuming insurer that accepts reinsurance of risks, and retains risk thereon within such limits, as the assuming insurer is otherwise authorized to insure in this state as provided in ORS 731.508.

(4) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state as provided in ORS 731.511. The director shall not allow credit to a domestic ceding insurer if the accreditation of the assuming insurer has been revoked by the director after notice and opportunity for hearing.

(5) Credit shall be allowed when the reinsurance is ceded to a foreign assuming insurer or a United States branch of an alien assuming insurer meeting all of the following requirements:

(a) The foreign assuming insurer must be domiciled in a state employing standards regarding credit for reinsurance that equal or exceed the standards applicable under this section. The United States branch of an alien assuming insurer must be entered through a state employing such standards.

(b) The foreign assuming insurer or United States branch of an alien assuming insurer must maintain a combined capital and surplus in an amount not less than $20,000,000. The requirement of this paragraph does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(c) The foreign assuming insurer or United States branch of an alien assuming insurer must submit to the authority of the director to examine its books and records.

(6) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund meeting the requirements of this subsection and additionally complies with other requirements of this subsection. The trust fund must be maintained in a qualified United States financial institution, as defined in ORS 731.510 (1), for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer must report annually to the director information substantially the same as that required to be reported on the annual statement form by ORS 731.574 by authorized insurers, in order to enable the director to determine the sufficiency of the trust fund. The following requirements apply to such a trust fund:

(a) In the case of a single assuming insurer, the trust fund must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers. In addition, the assuming insurer must maintain a trusteed surplus of not less than $20,000,000.

(b) In the case of a group including incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group.

(B) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the trust shall consist of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States.

(C) In addition to the trusts described in subparagraphs (A) and (B) of this paragraph, the group shall maintain in trust a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(D) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(E) Within 90 days after the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if certification is unavailable, financial statements of each underwriter member of the group prepared by independent certified public accountants.

(c) In the case of a group of incorporated insurers described in this paragraph, the trust must

be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group. This paragraph applies to a group of incorporated insurers under common administration that complies with the annual reporting requirements contained in this subsection and that has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation. Such a group must have an aggregate policyholders' surplus of $10,000,000,000 and must submit to the authority of this state to examine its books and records and bear the expense of the examination. The group shall also maintain a joint trusteed surplus of which $100,000,000 must be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities. Each member of the group shall make available to the director an annual certification of the member's solvency by the member's domiciliary regulator and its independent certified public accountant.

(d) The form of the trust and any amendment to the trust shall have been approved by the insurance commissioner of the state in which the trust is domiciled or by the insurance commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(e) The form of the trust and any trust amendments also shall be filed with the insurance commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the director. The trust must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(f) Not later than March 1 of each year, the trustees of each trust shall report to the director in writing the balance of the trust and listing the trust's investments at the preceding year end, and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31.

(7) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection (3), (4), (5) or (6) of this section, but only as to the insurance of risks located in jurisdictions in which the reinsurance is required by applicable law or regulation of that jurisdiction.

(8) If the assuming insurer is not authorized to transact insurance in this state or accredited as a reinsurer in this state, the director shall not allow the credit permitted by subsections (5) and (6) of this section unless the assuming insurer agrees in the reinsurance agreement to the provisions stated in this subsection. This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement. The assuming insurer must agree in the reinsurance agreement:

(a) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(b) To designate the director or a designated attorney as its true and lawful attorney upon whom any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company

may be served.

[*(9) Credit shall be allowed when the reinsurance is ceded to the Oregon Reinsurance Program established in section 18 of this 2017 Act.*]

[*(10)*] **(9)** If the assuming insurer does not meet the requirements of subsection (3), (4) or (5) of this section, the credit permitted by subsection (6) of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the applicable amount required by subsection (6)(a), (b) or (c) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of the grantor's state or country of domicile, the trustee shall comply with an order of the insurance commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance commissioner with regulatory oversight all the assets of the trust fund.

(b) The assets shall be distributed by and claims shall be filed with and valued by the insurance commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

(c) If the insurance commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the insurance commissioner according to the laws of that state and according to the terms of the trust agreement not inconsistent with the laws of that state.

(d) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this subsection.

**HOSPITAL ASSESSMENT**

**SECTION 26.** Section 1, chapter 736, Oregon Laws 2003, as amended by section 34, chapter 792, Oregon Laws 2009, is amended to read:

**Sec. 1.** As used in sections 1 to 9, chapter 736, Oregon Laws 2003:

(1) "Charity care" means costs for providing inpatient or outpatient care services free of charge or at a reduced charge because of the indigence or lack of health insurance of the patient receiving the care services.

(2) "Contractual adjustments" means the difference between the amounts charged based on the hospital's full established charges and the amount received or due from the payor.

(3)**(a)** "Hospital" [*has the meaning given that term in ORS 442.015*] **means a hospital licensed under ORS chapter 441**.

**(b)** "Hospital" does not include**:**

**(A)** Special inpatient care facilities[.]**;**

**(B) Hospitals that provide only psychiatric care;**

**(C) Pediatric specialty hospitals providing care to children at no charge; and**

**(D) Public hospitals other than hospitals created by health districts under ORS 440.315 to 440.410.**

(4) "Net revenue":

(a) Means the total amount of charges for inpatient or outpatient care provided by the hospital

to patients, less charity care, bad debts and contractual adjustments;

(b) Does not include revenue derived from sources other than inpatient or outpatient operations, including but not limited to interest and guest meals; and

(c) Does not include any revenue that is taken into account in computing a long term care facility assessment under sections 15 to 22, **24 and 29,** chapter 736, Oregon Laws 2003.

[*(5) "Waivered hospital" means a type A or type B hospital, as described in ORS 442.470, a hospital that provides only psychiatric care or a hospital identified by the Department of Human Services as appropriate for inclusion in the application described in section 4, chapter 736, Oregon Laws 2003.*]

**(5) "Type A hospital" has the meaning given that term in ORS 442.470.**

**(6) "Type B hospital" has the meaning given that term in ORS 442.470.**

**SECTION 27.** Section 2, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 780, Oregon Laws 2007, section 51, chapter 828, Oregon Laws 2009, section 17, chapter 867, Oregon Laws 2009, section 2, chapter 608, Oregon Laws 2013, and section 1, chapter 16, Oregon Laws 2015, is amended to read:

**Sec. 2.** (1) An assessment is imposed on the net revenue of each hospital in this state that is not a waivered hospital. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate needed to fund the services and costs identified in section 9, chapter 736, Oregon Laws 2003. The rate of assessment shall be imposed on the net revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

**(2) In addition to the assessment imposed by subsection (1) of this section, an assessment of 0.7 percent is imposed on the net revenue of each hospital in this state that is not a waivered hospital.**

[*(2)*] **(3)** The assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the 75th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection [*(6)*] **(7)** of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

[*(3)(a)*] **(4)(a)** To the extent permitted by federal law, [*aggregate*] assessments imposed under **subsection (1) of** this section may not exceed the **lesser of:**

**(A) A rate of 5.3 percent; or**

**(B) In the aggregate, the** total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

[*(A)*] **(i)** 30 percent of payments made to the hospitals on a fee-for-service basis by the authority for inpatient hospital services;

[*(B)*] **(ii)** 41 percent of payments made to the hospitals on a fee-for-service basis by the authority for outpatient hospital services; and

[*(C)*] **(iii)** Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed **under subsection (1) of this section** on or after July 1, 2015, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction

of funding in the legislatively adopted budget for hospital services under ORS 414.631, 414.651 and 414.688 to 414.745.

[*(4)*] **(5)** Notwithstanding subsection [*(3)*] **(4)** of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

[*(5)*] **(6)** Hospitals operated by the United States Department of Veterans Affairs and pediatric specialty hospitals providing care to children at no charge are exempt from the assessment imposed under this section.

[*(6)(a)*] **(7)(a)** The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, 2019, that will result in the collection occurring between December 15, 2019, and the time all Medicaid cost settlements are finalized for that calendar quarter.

(b) The authority shall prescribe by rule criteria for late payment of assessments.

**SECTION 28.** Section 2, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 780, Oregon Laws 2007, section 51, chapter 828, Oregon Laws 2009, section 17, chapter 867, Oregon Laws 2009, section 2, chapter 608, Oregon Laws 2013, and section 1, chapter 16, Oregon Laws 2015, and section 27 of this 2017 Act, is amended to read:

**Sec. 2.** (1) An assessment is imposed on the net revenue of each hospital in this state [*that is not a waivered hospital*]. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate needed to fund the services and costs identified in section 9, chapter 736, Oregon Laws 2003. The rate of assessment shall be imposed on the net revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

(2) In addition to the assessment imposed by subsection (1) of this section, an assessment of 0.7 percent is imposed on the net revenue of each hospital in this state that is not a [*waivered hospital*] **type A hospital or type B hospital**.

(3) [*The*] **Each** assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the [*75th*] **45th** day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection [*(7)*] **(6)** of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

(4)(a) To the extent permitted by federal law, assessments imposed under subsection (1) of this section may not exceed the lesser of:

(A) A rate of 5.3 percent; or

(B) In the aggregate, the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

(i) 30 percent of payments made to the hospitals on a fee-for-service basis by the authority for inpatient hospital services;

(ii) 41 percent of payments made to the hospitals on a fee-for-service basis by the authority for outpatient hospital services; and

(iii) Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed under sub-

section (1) of this section on or after July 1, 2015, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for hospital services under ORS 414.631, 414.651 and 414.688 to 414.745.

**(c) The director may impose a lower rate of assessment on type A hospitals and type B hospitals to take into account the hospitals' financial position.**

(5) Notwithstanding subsection (4) of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

[*(6) Hospitals operated by the United States Department of Veterans Affairs and pediatric specialty hospitals providing care to children at no charge are exempt from the assessment imposed under this section.*]

[*(7)(a)*] **(6)(a)** The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, [*2019*] **2021**, that will result in the collection occurring between December 15, [*2019*] **2021**, and the time all Medicaid cost settlements are finalized for that calendar quarter.

(b) The authority shall prescribe by rule criteria for late payment of assessments.

**SECTION 29.** Section 2, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 780, Oregon Laws 2007, section 51, chapter 828, Oregon Laws 2009, section 17, chapter 867, Oregon Laws 2009, section 2, chapter 608, Oregon Laws 2013, and section 1, chapter 16, Oregon Laws 2015, and sections 27 and 28 of this 2017 Act, is amended to read:

**Sec. 2.** (1) An assessment is imposed on the net revenue of each hospital in this state. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate needed to fund the services and costs identified in section 9, chapter 736, Oregon Laws 2003. The rate of assessment shall be imposed on the net revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

[*(2) In addition to the assessment imposed by subsection (1) of this section, an assessment of 0.7 percent is imposed on the net revenue of each hospital in this state that is not a type A hospital or type B hospital.*]

[*(3)*] **(2)** Each assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the 45th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection [*(6)*] **(5)** of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

[*(4)(a)*] **(3)(a)** To the extent permitted by federal law, **aggregate** assessments imposed under [*subsection (1) of*] this section may not exceed [*the lesser of:*]

[*(A) A rate of 5.3 percent; or*

[*(B) In the aggregate,*] the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

[*(i)*] **(A)** 30 percent of payments made to the hospitals on a fee-for-service basis by the authority for inpatient hospital services;

[*(ii)*] **(B)** 41 percent of payments made to the hospitals on a fee-for-service basis by the authority for outpatient hospital services; and

[*(iii)*] **(C)** Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed under [*subsection (1) of*] this section on or after July 1, 2015, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for hospital services under ORS 414.631, 414.651 and 414.688 to 414.745.

(c) The director may impose a lower rate of assessment on type A hospitals and type B hospitals to take into account the hospitals' financial position.

[*(5)*] **(4)** Notwithstanding subsection [*(4)*] **(3)** of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

[*(6)(a)*] **(5)(a)** The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, 2021, that will result in the collection occurring between December 15, 2021, and the time all Medicaid cost settlements are finalized for that calendar quarter.

(b) The authority shall prescribe by rule criteria for late payment of assessments.

**SECTION 30.** Section 3, chapter 736, Oregon Laws 2003, as amended by section 3, chapter 608, Oregon Laws 2013, is amended to read:

**Sec. 3.** [*(1)*] Notwithstanding section 2, chapter 736, Oregon Laws 2003, the Director of the Oregon Health Authority shall reduce the rate of assessment imposed under section 2 **(1)**, chapter 736, Oregon Laws 2003, to the maximum rate allowed under federal law if the reduction is required to comply with federal law.

[*(2) If federal law requires a reduction in the rate of assessments, the director shall, after consulting with representatives of the hospitals that are subject to the assessments, first reduce the distribution of moneys described in section 9 (2)(d), chapter 736, Oregon Laws 2003, by a corresponding amount.*]

**SECTION 31.** Section 5, chapter 736, Oregon Laws 2003, as amended by section 52, chapter 828, Oregon Laws 2009, and section 18, chapter 867, Oregon Laws 2009, is amended to read:

**Sec. 5.** (1) A hospital that fails to file a report or pay an assessment under section 2, chapter 736, Oregon Laws 2003, by the date the report or payment is due shall be subject to a penalty of up to $500 per day of delinquency. The total amount of penalties imposed under this section for each reporting period may not exceed five percent of the assessment for the reporting period for which penalties are being imposed.

(2) Penalties imposed under this section shall be collected by the Oregon Health Authority and deposited in the Oregon Health Authority Fund established under [*section 18, chapter 595, Oregon Laws 2009*] **ORS 413.101**.

(3) Penalties paid under this section are in addition to and not in lieu of [*the*] **any** assessment imposed under section 2, chapter 736, Oregon Laws 2003.

**SECTION 32.** Section 7, chapter 736, Oregon Laws 2003, as amended by section 5, chapter 608, Oregon Laws 2013, is amended to read:

**Sec. 7.** The Oregon Health Authority may audit the records of any hospital in this state to determine compliance with sections 1 to 9, chapter 736, Oregon Laws 2003[*, and section 1 of this 2013 Act*]. The authority may audit records at any time for a period of five years following the date an assessment is due to be reported and paid under section 2, chapter 736, Oregon Laws 2003.

**SECTION 33.** Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, section 59, chapter 602, Oregon Laws 2011, and section 7, chapter 608, Oregon Laws 2013, is amended to read:

**Sec. 9.** (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to [*414.750*] **414.745**, including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to [*414.750*] **414.745**;

(c) Making payments described in section 2 [*(3)(a)(C)*] **(4)(a)(B)(iii)**, chapter 736, Oregon Laws 2003;

(d) Making distributions, as described in section 1 (4) [*of this 2013 Act*]**, chapter 608, Oregon Laws 2013**, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2 **(1)**, chapter 736, Oregon Laws 2003; and

(e) Paying administrative costs incurred by the authority to administer section 1 [*of this 2013 Act*]**, chapter 608, Oregon Laws 2013,** and the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 [*(3)(b)*] **(4)(b)**, chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

**SECTION 34.** Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, section 59, chapter 602, Oregon Laws 2011, and section 7, chapter 608, Oregon Laws 2013, and section 33 of this 2017 Act, is amended to read:

**Sec. 9.** (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745, including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745;

(c) Making payments described in section 2 (4)(a)(B)(iii), chapter 736, Oregon Laws 2003;

(d) Making distributions, as described in section 1 (4), chapter 608, Oregon Laws 2013, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2 (1), chapter 736, Oregon Laws 2003; [*and*]

**(e) Making payments to coordinated care organizations to be used to provide additional reimbursement to type A hospitals and type B hospitals to improve and expand access to services for medical assistance recipients, to the extent permitted by federal requirements;**

**and**

[*(e)*] **(f)** Paying administrative costs incurred by the authority to administer section 1, chapter 608, Oregon Laws 2013, and the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (4)(b), chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

**SECTION 35.** Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, section 59, chapter 602, Oregon Laws 2011, and section 7, chapter 608, Oregon Laws 2013, and sections 33 and 34 of this 2017 Act, is amended to read:

**Sec. 9.** (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745 , including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745;

(c) Making payments described in section 2 (4)(a)(B)(iii), chapter 736, Oregon Laws 2003;

[*(d) Making distributions, as described in section 1 (4), chapter 608, Oregon Laws 2013, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2 (1), chapter 736, Oregon Laws 2003;*]

[*(e)*] **(d)** Making payments to coordinated care organizations to be used to provide additional reimbursement to type A hospitals and type B hospitals to improve and expand access to services for medical assistance recipients, to the extent permitted by federal requirements; and

[*(f)*] **(e)** Paying administrative costs incurred by the authority to administer [*section 1, chapter 608, Oregon Laws 2013, and*] the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (4)(b), chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

**SECTION 36.** Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, section 59, chapter 602, Oregon Laws 2011, and section 7, chapter 608, Oregon Laws 2013, and sections 33, 34 and 35 of this 2017 Act, is amended to read:

**Sec. 9.** (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the

Oregon Health Authority for the purpose of:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745 , including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745;

(c) Making payments described in section 2 [*(4)(a)(B)(iii)*] **(3)(a)(C)**, chapter 736, Oregon Laws 2003;

(d) Making payments to coordinated care organizations to be used to provide additional reimbursement to type A hospitals and type B hospitals to improve and expand access to services for medical assistance recipients, to the extent permitted by federal requirements; and

(e) Paying administrative costs incurred by the authority to administer the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 [*(4)(b)*] **(3)(b)**, chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

**SECTION 37.** Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, section 59, chapter 602, Oregon Laws 2011, and section 7, chapter 608, Oregon Laws 2013, and section 33 of this 2017 Act, is amended to read:

**Sec. 9.** (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of:

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003;

(b) Funding services under ORS 414.631, 414.651 and 414.688 to 414.745, including but not limited to increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.631, 414.651 and 414.688 to 414.745; **and**

(c) Making payments described in section 2 (4)(a)(B)(iii), chapter 736, Oregon Laws 2003;

[*(d) Making distributions, as described in section 1 (4), chapter 608, Oregon Laws 2013, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2 (1), chapter 736, Oregon Laws 2003; and*]

[*(e)*] **(d)** Paying administrative costs incurred by the authority to administer [*section 1, chapter 608, Oregon Laws 2013, and*] the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (4)(b), chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

**SECTION 37a.** Section 10, chapter 736, Oregon Laws 2003, as amended by section 3, chapter 780, Oregon Laws 2007, section 20, chapter 867, Oregon Laws 2009, section 8, chapter 608, Oregon Laws 2013, and section 6, chapter 16, Oregon Laws 2015, is amended to read:

**Sec. 10.** Sections 1 to 9, chapter 736, Oregon Laws 2003, apply to net revenues earned by hospitals during a period beginning October 1, 2015, and ending the earlier of September 30, [*2019*]

**2021**, or the date on which the assessment no longer qualifies for federal financial participation under Title XIX or XXI of the Social Security Act.

**SECTION 38.** Section 12, chapter 736, Oregon Laws 2003, as amended by section 4, chapter 780, Oregon Laws 2007, section 21, chapter 867, Oregon Laws 2009, section 9, chapter 608, Oregon Laws 2013, and section 3, chapter 16, Oregon Laws 2015, is amended to read:

**Sec. 12. (1)** Sections 1 to 9, chapter 736, Oregon Laws 2003, [*and section 1, chapter 608, Oregon Laws 2013,*] are repealed on January 2, [*2024*] **2026**.

**(2) Section 1, chapter 608, Oregon Laws 2013, is repealed on July 1, 2018.**

**SECTION 39.** Section 13, chapter 736, Oregon Laws 2003, as amended by section 5, chapter 780, Oregon Laws 2007, section 22, chapter 867, Oregon Laws 2009, section 10, chapter 608, Oregon Laws 2013, and section 4, chapter 16, Oregon Laws 2015, is amended to read:

**Sec. 13.** Nothing in the repeal of sections 1 to 9, chapter 736, Oregon Laws 2003, and section 1, chapter 608, Oregon Laws 2013, by section 12, chapter 736, Oregon Laws 2003, affects the imposition and collection of a hospital assessment under sections 1 to 9, chapter 736, Oregon Laws 2003, for a calendar quarter beginning before September 30, [*2019*] **2021**.

**SECTION 40.** Section 14, chapter 736, Oregon Laws 2003, as amended by section 6, chapter 780, Oregon Laws 2007, section 23, chapter 867, Oregon Laws 2009, and section 5, chapter 16, Oregon Laws 2015, is amended to read:

**Sec. 14.** Any moneys remaining in the Hospital Quality Assurance Fund on December 31, [*2023*] **2025**, are transferred to the General Fund.

**SECTION 41. The Oregon Health Authority shall ensure that the Oregon Health and Science University receives net reimbursement of at least 84 percent but no more than 100 percent of the university's costs of providing services that are paid for, in whole or in part, with Medicaid funds. Net reimbursement means all Medicaid payments less any amount that is transferred by the university to the authority.**

## FUNDING

**SECTION 42. (1) An amount is transferred to the Health System Fund established under section 2 of this 2017 Act from the unexpended balance of the Health Insurance Exchange Fund established under ORS 741.102, that equals the difference between the balance in the Health Insurance Exchange Fund and the projected expenditures from the Health Insurance Exchange Fund during the next six months.**

**(2) Any unexpended balance of the Oregon Medical Insurance Pool Account established in ORS 735.612 remaining of the effective date of this 2017 Act is transferred to the Health System Fund established under section 2 of this 2017 Act.**

**(3) The transfers described in subsections (1) and (2) of this section shall be made from moneys maintained, on the effective date of this 2017 Act, in the Health Insurance Exchange Fund and the Oregon Medical Insurance Pool Account.**

## OPERATIVE DATES, EFFECTIVE DATES, REPEALS AND TECHNICAL ADJUSTMENTS

**SECTION 43. Sections 3 to 12 of this 2017 Act and the amendments to ORS 291.055, 731.292 and 731.840 by sections 13 to 16 of this 2017 Act become operative on January 1, 2018.**

**SECTION 44.** **(1) If the Centers for Medicare and Medicaid Services permits the state to impose the assessment under section 2, chapter 736, Oregon Laws 2003, on type A hospitals and type B hospitals and to exclude from the assessment public hospitals other than health district hospitals:**

**(a) Section 41 of this 2017 Act and the amendments to sections 1, 2 and 9, chapter 736, Oregon Laws 2003, by sections 26, 28 and 34 of this 2017 Act become operative on the later of:**

**(A) January 1, 2018; or**

**(B) The date of the approval by the Centers for Medicare and Medicaid Services.**

**(b) The amendments to sections 3, 7 and 9, chapter 736, Oregon Laws 2003, by sections 30, 32 and 35 of this 2017 Act become operative on July 1, 2018.**

**(c) The amendments to sections 2 and 9, chapter 736, Oregon Laws 2003, by sections 29 and 36 of this 2017 Act become operative on July 1, 2019.**

**(2) If the Centers for Medicare and Medicare Services denies approval for the state to impose the assessment under section 2, chapter 736, Oregon Laws 2003, on type A hospitals and type B hospitals and to exclude from the assessment public hospitals other than health district hospitals, the amendments to section 9, chapter 736, Oregon Laws 2003, by section 37 of this 2017 Act become operative on July 1, 2018.**

**(3) The Director of the Oregon Health Authority shall notify the Legislative Counsel upon receipt of an approval or denial by the Centers for Medicare and Medicaid Services of permission to impose the assessment under section 2, chapter 736, Oregon Laws 2003, on type A hospitals and type B hospitals and to exclude from the assessment public hospitals other than health district hospitals.**

**SECTION 45.** **(1) Sections 18 to 22 of this 2017 Act and the amendments to ORS 731.509 and section 2, chapter 26, Oregon Laws 2016, by sections 23 and 24 of this 2017 Act become operative on the later of:**

**(a) The date the United States Department of Health and Human Services approves a waiver for state innovation under 42 U.S.C. 18052 in accordance with section 2, chapter 26, Oregon Laws 2016, as amended by section 24 of this 2017 Act; or**

**(b) January 1, 2018.**

**(2) The Director of the Department of Consumer and Business Services shall notify the Legislative Counsel upon receipt of the approval or denial of funding for the Oregon Reinsurance Program under 42 U.S.C. 18052.**

**SECTION 46.** **The amendments to ORS 731.509 by section 25 of this 2017 Act become operative on January 2, 2024.**

**SECTION 47.** **Section 15, chapter 389, Oregon Laws 2015, is repealed.**

**SECTION 48.** **Sections 18 to 22 of this 2017 Act are repealed on January 2, 2024.**

**SECTION 49.** **The Department of Consumer and Business Services may take any action before the operative date specified in sections 43 and 45 of this 2017 Act for sections 2 to 12 and 18 to 22 of this 2017 Act and the amendments to ORS 291.055, 731.292, 731.509 and 731.840 and section 2, chapter 26, Oregon Laws 2016, by sections 13 to 16, 23 and 24 of this 2017 Act that is necessary for the department to carry out sections 2 to 12 and 18 to 22 of this 2017 Act and the amendments to ORS 291.055, 731.292, 731.509 and 731.840 and section 2, chapter 26, Oregon Laws 2016, by sections 13 to 16, 23 and 24 of this 2017 Act on the operative date specified in sections 43 and 45 of this 2017 Act.**

**SECTION 50.** **The unit captions used in this 2017 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2017 Act.**

**SECTION 51.** **This 2017 Act takes effect on the 91st day after the date on which the 2017 regular session of the Seventy-ninth Legislative Assembly adjourns sine die.**

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