House Bill 3428

Sponsored by Representative PARRISH

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Enrolls specified public employees in coordinated care organizations. Authorizes enrollment of other individuals not otherwise eligible to enroll in coordinated care organizations. Abolishes Oregon Educators Benefit Board. Incorporates duties of Oregon Educators Benefit Board into Public Employees' Benefit Board. Removes Public Employees' Benefit Board responsibility for providing health benefits. Temporarily caps hospital reimbursement paid by boards to hospitals at 180 percent of Medicare amount.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health; creating new provisions; amending ORS 192.556, 196.165, 238.410, 238.415, 238.538, 240.309, 243.061, 243.105, 243.107, 243.125, 243.129, 243.140, 243.145, 243.163, 243.185, 243.215, 243.221, 243.252, 243.256, 243.275, 243.285, 243.302, 243.879, 279A.025, 292.051, 346.565, 350.355, 352.129, 352.237, 413.011, 413.017, 413.260, 414.312, 414.314, 414.625, 414.661, 414.764, 421.352, 442.396, 471.752, 565.456, 565.470, 653.300, 656.247, 741.300, 741.310, 743A.058, 743B.601, 743B.810 and 757.822 and section 4, chapter 771, Oregon Laws 2013, section 1, chapter 389, Oregon Laws 2015, and section 3, chapter 575, Oregon Laws 2015; repealing ORS 243.135, 243.142, 243.160, 243.205, 243.256, 243.303, 243.860, 243.862, 243.864, 243.866, 243.867, 243.868, 243.870, 243.872, 243.874, 243.876, 243.878, 243.879, 243.880, 243.882, 243.884 and 243.886; and declaring an emergency.

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

HEALTH BENEFITS FOR PUBLIC EMPLOYEES

SECTION 1. (1) The Task Force on Publicly Funded Health Benefits is established.

(2) The task force consists of 11 members appointed as follows:

(a) The President of the Senate shall appoint one member from among members of the Senate.

(b) The Senate minority leader shall appoint one member from among the members of the Senate.

(c) The Speaker of the House of Representatives shall appoint one member from among the members of the House of Representatives.

(d) The minority leader in the House of Representatives shall appoint one member from among the members of the House of Representatives.

(e) The Director of the Department of Consumer and Business Services or the director's designee.

(f) The Director of the Oregon Health Authority or the director's designee.

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.

(g) The Governor shall appoint:

(A) One member representing a labor organization that represents state or local public employees;

(B) One member representing cities;

(C) One member representing counties;

(D) One member representing school districts; and

(E) One member representing institutions of higher education.

(3) The task force shall compare, contrast and evaluate the benefit structures of the state medical assistance program and the health benefits offered by the Public Employees' Benefit Board, the Oregon Educators Benefit Board and other public employers.

(4) The task force may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence and require the production of books, papers, correspondence, memoranda, agreements or other documents or records which the task force deems relevant or material to their inquiry.

(5) A majority of the voting members of the task force constitutes a quorum for the transaction of business.

(6) Official action by the task force requires the approval of a majority of the voting members of the task force.

(7) The task force shall elect one of its members to serve as chairperson.

(8) If there is a vacancy for any cause, the appointing authority shall make an appointment to become immediately effective.

(9) The task force shall meet at times and places specified by the call of the chairperson or of a majority of the voting members of the task force.

(10) The task force may adopt rules necessary for the operation of the task force.

(11) The task force shall submit a report in the manner provided by ORS 192.245, and may include recommendations for legislation, to the interim committees of the Legislative Assembly related to health no later than September 15, 2018.

(12) The Legislative Policy and Research Director may employ persons necessary for the performance of the functions of the task force. The Legislative Policy and Research Director shall fix the duties and amounts of compensation of these employees. The task force shall use the services of continuing legislative staff, without employing additional persons, to the greatest extent practicable.

(13) Members of the Legislative Assembly appointed to the task force are nonvoting members of the task force and may act in an advisory capacity only.

(14) Members of the task force who are not members of the Legislative Assembly are not entitled to compensation or reimbursement for expenses and serve as volunteers on the task force.

(15) All agencies of state government, as defined in ORS 174.111, are directed to assist the task force in the performance of the task force's duties and, to the extent permitted by laws relating to confidentiality, to furnish information and advice the members of the task force consider necessary to perform their duties.

SECTION 2. As used in sections 2 and 3 of this 2017 Act and ORS 238.538, 243.107, 243.140, 243.163, 243.215, 243.252, 243.285, 243.302 and 350.355:

(1) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(2) "District" means a common school district, a union high school district, an education

service district, as defined in ORS 334.003, or a community college district, as defined in ORS 341.005.

(3)(a) "Eligible employee" includes an officer or employee of:

(A) A state agency;

(B) A public university listed in ORS 352.002 or the Oregon Health and Science University;

(C) A local government that elects to enroll its employees in a coordinated care organization; and

(D) Whether or not retired, a state agency, university, the Oregon Health and Science University, a district or local government that elects to enroll its employees in a coordinated care organization, who:

(i) Is receiving a service retirement allowance, a disability retirement allowance or a pension under the Public Employees Retirement System or is receiving a service retirement allowance, a disability retirement allowance or a pension under any other retirement or disability benefit plan or system offered by the State of Oregon for its officers and employees;

(ii) Is eligible to receive a service retirement allowance under the Public Employees Retirement System and has reached earliest retirement age under ORS chapter 238;

(iii) Is eligible to receive a pension under ORS 238A.100 to 238A.250, and has reached earliest retirement age as described in ORS 238A.165; or

(iv) Is eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by the State of Oregon and has attained earliest retirement age under the plan or system.

(b) "Eligible employee" does not include individuals:

(A) Engaged as independent contractors;

(B) Whose periods of employment in emergency work are on an intermittent or irregular basis;

(C) Who are employed on less than half-time basis unless the individuals are employed in positions classified as job-sharing positions, or the individuals are defined as eligible under rules of the board;

(D) Temporarily employed or appointed under ORS 240.309;

(E) Provided sheltered employment or make-work by the state in an employment or industries program maintained for the benefit of such individuals;

(F) Provided student health care services in conjunction with their enrollment as students at a public university listed in ORS 352.002; or

(G) Who are members of a collective bargaining unit that represents police officers or firefighters.

(4) "Family member" means an eligible employee's spouse and any unmarried child or stepchild within age limits and other conditions imposed by the Oregon Health Authority with regard to unmarried children or stepchildren.

(5) "Local government" means any city, county or special district in this state, or any intergovernmental entity created under ORS chapter 190.

(6) "State agency" means every state officer, board, commission, department or other activity of state government.

SECTION 3. (1) State agencies, districts, public universities and the Oregon Health and Science University shall provide health benefits to eligible employees by offering the employees enrollment in coordinated care organizations that contract with the Oregon Health

Authority under ORS 414.625.

(2) A local government may elect to provide health benefits to its eligible employees by offering the employees enrollment in coordinated care organizations that contract with the authority under ORS 414.625.

(3) Individuals described in ORS 196.165, 238.538, 243.140, 243.163, 346.565 and 471.752 may elect to enroll in a coordinated care organization for health benefits.

(4) The authority is responsible for:

(a) The enrollment in coordinated care organizations of eligible employees and other individuals designated in subsection (3) of this section;

(b) Renewing enrollments; and

(c) Ensuring that enrollment assistance is readily available to eligible employees and other individuals designated in subsection (3) of this section.

SECTION 4. Section 3 of this 2017 Act is amended to read:

Sec. 3. (1) State agencies, **local governments,** districts, universities and the Oregon Health and Science University shall provide health benefits to eligible employees by offering the employees enrollment in coordinated care organizations that contract with the Oregon Health Authority under ORS 414.625.

[*(2) A local government may elect to provide health benefits to its eligible employees by offering the employees enrollment in coordinated care organizations that contract with the authority under ORS 414.625.*]

[*(3)*] **(2)** Individuals described in ORS 196.165, 235.538, 243.140, 243.163, 346.565 and 471.752 may elect to enroll in a coordinated care organization for health benefits.

[*(4)*] **(3)** The authority is responsible for:

(a) The enrollment in coordinated care organizations of eligible employees and other individuals designated in subsection [*(3)*] **(2)** of this section;

(b) Renewing enrollments; and

(c) Ensuring that enrollment assistance is readily available to eligible employees and other individuals designated in subsection [*(3)*] **(2)** of this section.

SECTION 5. ORS 238.538 is amended to read:

238.538. (1) A judge member who elects to retire under ORS 238.535 (1)(b):

(a) Shall continue to be eligible as a nonretired employee [*for health benefit plans contracted for under ORS 243.135*] **to enroll in a coordinated care organization under section 3 of this 2017 Act** during the time that the judge member is serving as a pro tem judge under ORS 238.535 (1)(c); and

(b) Subject to availability of funding, shall continue to receive the monthly state contribution as payment of all or part of the cost of a health benefit plan during the time that the judge member is serving as a pro tem judge under ORS 238.535 (1)(c).

(2) A judge member receiving the monthly state contribution as payment of all or part of the cost of a health benefit plan under this section is not eligible for payments against the cost of Medicare supplemental insurance under ORS 238.420 until such time as the judge member is no longer serving as a pro tem judge under ORS 238.535 (1)(c).

SECTION 6. ORS 243.107 is amended to read:

243.107. A person employed by a public university listed in ORS 352.002 or the Oregon Health and Science University may be considered an eligible employee for participation in [*one of the group benefit plans described in ORS 243.135*] **a coordinated care organization** if the governing board of

the public university, or the Oregon Health and Science University Board of Directors for Oregon Health and Science University employees, determines that funds are available therefor and if:

(1) Notwithstanding [*ORS 243.105 (4)(b)(F)*] **section 2 (3)(b)(F) of this 2017 Act**, the person is a student enrolled in an institution of higher education and is employed as a graduate teaching assistant, graduate research assistant or a fellow at the institution and elects to participate; or

(2) Notwithstanding ORS [*243.105 (4)(b)(B) or (C)*] **section 2 (3)(b)(B) or (C) of this 2017 Act**, the person is employed on a less than half-time basis in an unclassified instructional or research support capacity and elects to participate.

SECTION 7. ORS 243.140 is amended to read:

243.140. [*(1) Persons whose homes are certified as a foster home by the Department of Human Services under ORS 418.630 and as defined in ORS 418.625 (3) may participate in a health benefit plan available to employees pursuant to ORS 243.105 to 243.285 at the expense of the foster parent. For such purposes, foster parents shall be considered eligible employees.*]

[*(2) A person who maintains a developmental disability child foster home that is certified by the department under ORS 443.830 and 443.835 may participate in a health benefit plan available to employees pursuant to ORS 243.105 to 243.285 at the expense of the person. For such purposes, the person maintaining the home shall be considered an eligible employee.*]

[*(3) Persons who participate in the health benefit plan pursuant to subsections (1) and (2) of this section may also participate in a dental plan available to employees pursuant to ORS 243.105 to 243.285 at the expense of the foster parent or the person maintaining the developmental disability child foster home.*]

(1) A person whose home is certified as a foster home by the Department of Human Services under ORS 418.630 and as defined in ORS 418.625 (3) may enroll in a coordinated care organization available to public employees under section 3 of this 2017 Act at the expense of the foster parent.

(2) A person who maintains a developmental disability child foster home that is certified by the department under ORS 443.830 and 443.835 may enroll in a coordinated care organization available to public employees at the expense of the person.

SECTION 8. ORS 243.163 is amended to read:

243.163. A member of the Legislative Assembly who is receiving a pension or annuity under ORS 238.092 (1)(a) or 238A.250 (1) shall be eligible to participate as a retired state officer in [*one of the group benefit plans described in ORS 243.135*] **a coordinated care organization under section 3 of this 2017 Act** after the member ceases to be a member of the Legislative Assembly if the member applies [*to the Public Employees' Benefit Board*] **to enroll** within 60 days after the member ceases to be a member of the Legislative Assembly.

SECTION 9. ORS 243.215 is amended to read: **added**

243.215. Any eligible employee unable to participate in [*one or more of the plans described in ORS 243.135 (1)*] **a coordinated care organization in accordance with section 3 of this 2017 Act** solely because the employee is assigned to perform duties outside the state may be eligible to receive the monthly state or local government contribution, less administrative expenses, as payment of all or part of the cost of a health benefit plan of choice, subject to the approval of [*the Public Employees' Benefit Board and such rules as the board may adopt*] **their employer**.

SECTION 10. ORS 243.252 is amended to read:

243.252. (1) The state may pay none of the cost of [*making health benefit plan coverage available to*] **enrolling** a retired state employee who is an eligible employee and [*to*] family members **in a**

coordinated care organization or may agree, by collective bargaining agreement or otherwise, to pay part or all of that cost.

(2) Nothing in subsection (1) of this section or other law[*, except ORS 243.886,*] prohibits a collective bargaining unit from agreeing with an employer that is a public body, as defined in ORS 174.109, to establish a retiree medical trust, voluntary employees' beneficiary association, health reimbursement arrangement or other agreement for health care expenses of employees or retirees if the provisions of the trust, association, arrangement or other agreement comply with the requirements of the Insurance Code.

SECTION 11. ORS 243.285 is amended to read:

243.285. (1) Upon receipt of the request in writing of an eligible employee [*so to do*], the payroll disbursing officer authorized to disburse funds in payment of the salary or wages of the eligible employee may deduct from the salary or wages of the employee an amount of money indicated in the request for payment of the applicable amount set forth in benefit plans selected by the employee or selected on the employee's behalf for:

(a) [*Group health and related services and supplies, including such insurance for family members of*] **Enrolling** the eligible employee **and family members in a coordinated care organization**.

(b) Group life insurance, including life insurance for family members of the eligible employee.

[*(c) Group dental and related services and supplies, or any other remedial care recognized by state law and related services and supplies, recognized under state law, including such insurance for family members of the eligible employee.*]

[*(d)*] **(c)** Group indemnity insurance for accidental death and dismemberment and for loss of income due to accident, sickness or other disability, including such insurance for family members of the eligible employee.

[*(e)*] **(d)** Other benefits, including self-insurance programs, that are approved and provided by the Public Employees' Benefit Board.

(2) Moneys deducted under subsection (1) of this section shall be paid over promptly:

(a) To the carriers **or coordinated care organizations,** or persons responsible for payment of premiums to carriers **or coordinated care organizations**, in accordance with the terms of the contracts made by the eligible employees or on their behalf; or

(b) With respect to self-insurance benefits, in accordance with rules, procedures and directions of the Public Employees' Benefit Board.

SECTION 12. ORS 243.302 is amended to read:

243.302. The [*Public Employees' Benefit Board*] **Oregon Health Authority** may group retired state employees and state employees who are not retired for the purpose of entering into contracts [*for health insurance coverage*] **with coordinated care organizations**.

SECTION 13. ORS 292.051 is amended to read:

292.051. (1) [*Except as authority over contracts for health benefit plans described in ORS 243.135 is vested in the Public Employees' Benefit Board,*] Upon receipt of the request in writing of an officer or employee so to do, the state official authorized to disburse funds in payment of the salary or wages of the officer or employee may deduct from the salary or wages of the officer or employee an amount of money indicated in the request for payment of the applicable amount set forth in benefit plans selected by the officers or employees or in their behalf for:

(a) Group life insurance, including life insurance for dependents of officers or employees.

[*(b) Group dental and related services and supplies, or any other remedial care recognized by state law and related services and supplies, other than medical, surgical or hospital care, recognized under*

state law, including such insurance for dependents of state officers or employees.]

(b) Premiums due to maintain enrollment in a coordinated care organization as provided in section 3 of this 2017 Act.

(c) Group indemnity insurance for accidental death and dismemberment and for loss of income due to accident, sickness or other disability, including such insurance for dependents of state officers or employees.

(d) Automobile casualty insurance under a monthly payroll deduction program endorsed or offered by an employee organization representing 500 or more state employees. Membership in the employee organization is not a requirement for participation in this program.

(e) Legal insurance under a monthly payroll deduction program endorsed or offered by an employee organization representing 500 or more state employees.

(f) Self-insurance programs that are approved and provided by the Public Employees' Benefit Board.

(2) The Oregon Health Authority may establish and collect a fee to cover costs of administering this section.

(3) No state official authorized to disburse funds in payment of salaries or wages is required to make deductions as authorized by subsection (1) of this section for more than one benefit plan of the type referred to in each of the paragraphs in subsection (1) of this section per eligible employee.

(4) Moneys deducted under subsection (1) of this section shall be paid over promptly:

(a) To the insurance companies, agencies**, coordinated care organizations** or hospital associations, or persons responsible for payment of premiums to the companies, agencies**, coordinated care organizations** or associations, in accordance with the terms of the contracts made by the officers or employees or in their behalf; or

(b) With respect to self-insurance benefits, in accordance with rules, procedures and directions of the Public Employees' Benefit Board.

(5) As used in this section, "officer or employee" means all persons who receive salaries or wages disbursed by any state official.

SECTION 14. ORS 350.355 is amended to read:

350.355. (1) Subject to ORS 352.237 [*and any group health and welfare insurance benefit plan developed under ORS 352.237*], a part-time faculty member at a public institution of higher education is eligible for the same health care benefits as full-time faculty members if the part-time faculty member is eligible for membership in the Public Employees Retirement System or another plan authorized under ORS chapter 238 or 238A by teaching either at a single public institution of higher education or in aggregate at multiple public institutions of higher education during the prior year.

(2) A part-time faculty member at a public institution of higher education shall pay all [*insurance*] premiums for [*health care benefits*] **enrolling in a coordinated care organization as provided in section 3 of this 2017 Act** unless otherwise provided for by the policy of the institution or by collective bargaining at the institution.

SECTION 15. ORS 352.129 is amended to read:

352.129. (1) Notwithstanding ORS 352.087 and 352.102 and section 169, chapter 768, Oregon Laws 2013, the amendments to ORS [*243.107 and*] 351.094 (renumbered 352.237) by sections 88 and 113, chapter 768, Oregon Laws 2013, and the operative date set forth in section 171, chapter 768, Oregon Laws 2013, until July 1, 2019, each university with a governing board shall continue to participate with other public universities listed in ORS 352.002 in all shared administrative services relating to:

(a) The following employee benefits:

(A) [*Group insurance or deferred compensation plans authorized by ORS 352.237*] **Enrolling eligible employees in coordinated care organizations as provided in section 3 of this 2017 Act**;

(B) The Public Employees Retirement System or another plan authorized under ORS chapter 238 or 238A;

(C) The Optional Retirement Plan authorized by ORS 243.800; and

(D) A public university tax-deferred investment plan that obtains the advantages of 26 U.S.C. 403(b) and is authorized by ORS 243.820; and

(b) Collective bargaining with any statewide bargaining unit that includes employees of two or more public universities listed in ORS 352.002.

(2) During the period a public university listed in ORS 352.002 is required to participate in shared administrative services under subsection (1) of this section, the public university must provide the same scope and overall value of each employee benefit listed in subsection (1)(a) of this section as is required by the statutes referenced in subsection (1)(a) of this section.

(3) The shared administrative services listed in subsection (1) of this section must be done under the same terms, conditions, funding model and policy frameworks as those that exist on August 14, 2013, until July 1, 2015. On and after July 1, 2015, public universities listed in ORS 352.002 may choose to participate in shared services under an alternative shared services model.

(4)(a) Two or more public universities listed in ORS 352.002 may participate in shared services not described in subsection (1) of this section, including but not limited to shared services involving legal services and information technology.

(b) If a public university listed in ORS 352.002, or a community college, negotiates a contract with one or more third party financial firms, as defined in ORS 348.015, to provide disbursement and management services of financial aid funds, or management of financial accounts, to enrolled students, the public university or community college shall undertake reasonable efforts to establish collaboration agreements with other public universities or community colleges to negotiate the services.

(5)(a) A university with a governing board shall participate in shared services providing for maintenance of federal tax benefits relating to state bonds issued for the benefit of the university prior to April 30, 2015, unless the university opts out of shared services as described in paragraph (b) of this subsection.

(b) A university with a governing board may opt out of the shared services described in paragraph (a) of this subsection only if the Oregon Department of Administrative Services has adopted rules under ORS 286A.863 relating to standards, terms and conditions for maintaining federal tax benefits that apply to universities with governing boards that opt out of shared services described in paragraph (a) of this subsection.

(c) As used in this subsection, "federal tax benefits" has the meaning given that term in ORS 286A.830.

SECTION 16. ORS 352.237 is amended to read:

352.237. (1) The governing board of each public university listed in ORS 352.002 shall [*provide group insurance to*] **enroll** employees of the university [*through the Public Employees' Benefit Board or may elect to provide an alternative group health and welfare insurance benefit plan to employees of the university on or after October 1, 2016, if the benefit plan is offered through the health insurance exchange under ORS 741.310, unless their participation is precluded by federal law*] **in a coordinated care organization as provided in section 3 of this 2017 Act**.

[*(2) For the purposes of ORS 243.555 to 243.575, if the governing board of a public university listed*

in ORS 352.002 chooses not to participate in the benefit plans offered through the Public Employees' Benefit Board, the governing board may have the authority granted to the Public Employees' Benefit Board under ORS 243.555 to 243.575 for the administration of an appropriate expense reimbursement plan.]

[*(3)*] **(2)** The governing board of each public university listed in ORS 352.002 shall offer one or more deferred compensation plans to employees of the university. The governing board shall choose whether to offer its employees the state deferred compensation plan established under ORS 243.401 to 243.507 or another deferred compensation plan that the governing board elects to make available to the employees of the university.

SECTION 17. ORS 653.300 is amended to read:

653.300. (1) **Except as provided in section 3 of this 2017 Act,** each public or private employer in this state [*which*] **that** offers its employees a health benefit plan and employs not fewer than 25 employees, and each employee benefit fund in this state with not fewer than 25 members which offers its members any form of health benefit, shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization which provides health care services in the geographic areas in which a substantial number of such employees or members reside. Where there is a prevailing collective bargaining agreement, the selection of the health maintenance organizations to be made available to the employees shall be made under the agreement.

(2) No employer or benefits fund in this state shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees.

(3) Notwithstanding subsection (1) of this section, no employer or benefits fund need provide such an option unless at least 25 employees or members agree to participate in a health maintenance organization.

(Retired Public Employees)

SECTION 18. ORS 238.410 is amended to read:

238.410. (1) As used in this section:

(a) "Carrier" means**:**

(A) An insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services[*,*]**;**

(B) An insurance company or health care service contractor licensed or certified in another state that is operating under the laws of that state[*, or*]**;**

(C) Two or more [*of those companies or contractors*] **insurance companies or health care service contractors** acting together pursuant to a joint venture, partnership or other joint means of operation**; or**

(D) A coordinated care organization.

(b) "Coordinated care organization" has the meaning given that term in ORS 414.025.

[*(b)*] **(c)** "Eligible person" means:

(A) A member of the Public Employees Retirement System who is retired for service or disability and is receiving a retirement allowance or benefit under the system, and a spouse or dependent of that member;

(B) A person who is a surviving spouse or dependent of a deceased retired member of the system or the surviving spouse or dependent of a member of the system who had not retired but who had reached earliest retirement age at the time of death;

(C) A person who is receiving retirement pay or a pension calculated under ORS 1.314 to 1.380 (1989 Edition), and a spouse or dependent of that person; or

(D) A surviving spouse or dependent of a deceased retired member of the system or of a person who was receiving retirement pay or a pension calculated under ORS 1.314 to 1.380 (1989 Edition) if the surviving spouse or dependent was covered at the time of the decedent's death by a health care insurance plan contracted for under this section.

[*(c)*] **(d)** "Health care" means medical, surgical, hospital or any other remedial care recognized by state law and related services and supplies and includes comparable benefits for persons who rely on spiritual means of healing.

(e) "Health care insurance" means:

(A) A policy or certificate of health insurance offered by a person with a certificate of authority to transact insurance in this state;

(B) A health care service contract, as defined in ORS 750.005; or

(C) Health care provided by a coordinated care organization.

(2) The Public Employees Retirement Board shall conduct a continuing study and investigation of all matters connected with the providing of health care insurance [*protection*] to eligible persons. The board shall design benefits, devise specifications, invite proposals, analyze carrier responses to advertisements for proposals and do acts necessary to award contracts to provide health care insurance, including insurance that provides coverage supplemental to federal Medicare coverage, with emphasis on features based on health care cost containment principles, for eligible persons. The board is not subject to the provisions of ORS chapters 279A and 279B, except ORS 279B.235, in awarding contracts under the provisions of this section. The board shall establish procedures for inviting proposals and awarding contracts under this section.

(3) The board shall enter into a contract with a carrier to provide health care insurance for eligible persons for a one or two-year period. The board may enter into more than one contract with one or more carriers, contracting jointly or severally, if in the opinion of the board it is necessary to do so to obtain maximum coverage at minimum cost and consistent with the health care insurance needs of eligible persons. The board periodically shall review a current contract or contracts and make suitable study and investigation for the purpose of determining whether a different contract or contracts can and should, in the best interest of eligible persons, be entered into. If it would be advantageous to eligible persons to do so, the board shall enter into a different contract or contracts. Contracts shall be signed by the chairperson on behalf of the board.

(4) Except as provided in ORS 238.415 and 238.420, the board may deduct monthly from the retirement allowance or benefit, retirement pay or pension payable to an eligible person who elects to participate in [*a*] health care insurance [*plan*] the monthly cost of the coverage for the person under a health care insurance contract entered into under this section and the administrative costs incurred by the board under this section, and shall pay those amounts into the Standard Retiree Health Insurance Account established under subsection (7) of this section. The board by rule may establish other procedures for collecting the monthly cost of the coverage and the administrative costs incurred by the board under this section if the board does not deduct those costs from the retirement allowance or benefit, retirement pay or pension payable to an eligible person.

(5) Subject to applicable provisions of ORS chapter 183, the board may make rules not incon-

sistent with this section to determine the terms and conditions of eligible person participation and coverage and otherwise to implement and carry out the purposes and provisions of this section and ORS 238.420.

(6) The board may retain consultants, brokers or other advisory personnel, organizations specializing in health care cost containment or other administrative services when it determines the necessity and, subject to the State Personnel Relations Law, shall employ such personnel as are required to assist in performing the functions of the board under this section.

(7) Pursuant to section 401(h) of the Internal Revenue Code, the Standard Retiree Health Insurance Account is established within the Public Employees Retirement Fund, separate and distinct from the General Fund. All payments made by eligible persons for health **care** insurance [*coverage*] provided under this section shall be held in the account. Interest earned by the account shall be credited to the account. All moneys in the account are continuously appropriated to the Public Employees Retirement Board and may be used by the board only to pay the cost of health insurance coverage under this section and to pay the administrative costs incurred by the board under this section.

(8) The sum of all amounts paid by eligible persons into the Standard Retiree Health Insurance Account, by participating public employers into the Retiree Health Insurance Premium Account under ORS 238.415, and by participating public employers into the Retirement Health Insurance Account under ORS 238.420, may not exceed 25 percent of the aggregate contributions made by participating public employers to the Public Employees Retirement Fund on or after July 11, 1987, not including contributions made by participating public employers to fund prior service credits.

(9) Until all liabilities for health [*benefits*] **care insurance** under the system are satisfied, contributions and earnings in the Standard Retiree Health Insurance Account, the Retiree Health Insurance Premium Account under ORS 238.415 and the Retirement Health Insurance Account under ORS 238.420 may not be diverted or otherwise put to any use other than providing health [*benefits*] **care insurance** and payment of reasonable costs incurred in administering this section and ORS 238.415 and 238.420. Upon satisfaction of all liabilities for providing health [*benefits*] **care insurance** under this section, any amount remaining in the Standard Retiree Health Insurance Account shall be returned to the participating public employers who have made contributions to the account. The distribution shall be made in such equitable manner as the board determines appropriate.

(Coordinated Care Organization Requirements Applicable to Enrollees Who Are Not Medical Assistance Recipients)

SECTION 19. ORS 414.625 is amended to read:

414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria adopted by the authority under this section must include, but are not limited to, the coordi-

nated care organization's demonstrated experience and capacity for:

(a) Managing financial risk and establishing financial reserves.

(b) Meeting the following minimum financial requirements:

(A) **For coordinated care organizations that serve only medical assistance recipients:**

(i) Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

[*(B)*] **(ii)** Maintaining a net worth in an amount equal to at least five percent of the average combined revenue in the prior two quarters of the participating health care entities.

(B) For coordinated care organizations that enroll individuals listed in section 3 of this 2017 Act, maintaining an amount of restricted reserves determined by the authority to be necessary to ensure the financial stability of the coordinated care organizations, and calculated annually in accordance with accepted actuarial principles and practices.

(c) Operating within a fixed global budget.

(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes.

(e) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services.

(f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

(2) In addition to the criteria specified in subsection (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the authority so that:

(a) Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.

(b) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.

(c) The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes, behavioral health homes or other models that support patient centered primary care and behavioral health care and individualized care plans to the extent feasible.

(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

(e) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, as defined in ORS 413.550, community health workers and personal health navigators who meet competency standards established by the authority under ORS 414.665 or who are certified by the Home Care Commission under ORS 410.604.

(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

(h) Each coordinated care organization complies with the safeguards for members described in

ORS 414.635.

(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.627.

(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions.

(k) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization:

(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.

(B) Are educated about the integrated approach and how to access and communicate within the integrated system about a patient's treatment plan and health history.

(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication.

(D) Are permitted to participate in the networks of multiple coordinated care organizations.

(E) Include providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures and objective quality information and are removed if the providers fail to meet objective quality standards.

(G) Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.464 and 442.466.

(m) Each coordinated care organization uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.

(n) Each coordinated care organization participates in the learning collaborative described in ORS 413.259 (3).

(o) Each coordinated care organization has a governing body that includes:

(A) Persons that share in the financial risk of the organization who must constitute a majority of the governing body;

(B) The major components of the health care delivery system;

(C) At least two health care providers in active practice, including:

(i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and

(ii) A mental health or chemical dependency treatment provider;

(D) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

(E) At least one member of the community advisory council.

(p) Each coordinated care organization's governing body establishes standards for publicizing the activities of the coordinated care organization and the organization's community advisory councils, as necessary, to keep the community informed.

(3) The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organizations.

(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with coordinated care organizations; and

(c) Allow more than one coordinated care organization to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) On or before July 1, 2014, each coordinated care organization must have a formal contractual relationship with any dental care organization that serves members of the coordinated care organization in the area where they reside.

SECTION 20. ORS 414.764 is amended to read:

414.764. (1) The Oregon Health Authority may reimburse a pharmacist or pharmacy for any health service:

(a) Provided to a medical assistance recipient who is not enrolled in a coordinated care organization or a prepaid managed care health services organization;

(b) That is within the lawful scope of practice of a pharmacist; and

(c) If the authority determines the service is within the types and extent of health care and services to be provided to medical assistance recipients under ORS 414.065.

(2) A coordinated care organization may reimburse a pharmacist or pharmacy for any health service:

(a) Provided to a medical assistance recipient who is enrolled in [*the coordinated care organization or*] a prepaid managed care health services organization [*that*] **and to any member of the coordinated care organization if the prepaid managed care health services organization or coordinated care organization** enters into a clinical pharmacy agreement with the pharmacist or pharmacy; and

(b) That is within the lawful scope of practice of a pharmacist.

PUBLIC EMPLOYEES BENEFIT BOARD RESPONSIBILITY FOR ADMINISTERING BENEFIT PLANS FOR PUBLIC EMPLOYEES AND EDUCATORS

SECTION 21. ORS 238.415 is amended to read:

238.415. (1) As used in this section:

(a) "Board" means the Public Employees Retirement Board.

(b) "Eligible retired state employee" means:

(A) A retired member of the Public Employees Retirement System who was a state employee at the time of retirement, is retired for service or disability, is receiving a retirement allowance or benefit under the system, had eight years or more of qualifying service in the system at the time of retirement or is receiving a disability retirement allowance including a pension computed as if the member had eight years or more of creditable service in the system at the time of retirement, and has attained earliest service retirement age but is not eligible for federal Medicare coverage; or

(B) A person who is a surviving spouse or dependent of a deceased eligible retired state employee as provided in subparagraph (A) of this paragraph at the time of death, who:

(i) Is receiving a retirement allowance or benefit under the system; or

(ii) Was covered at the time of the eligible retired state employee's death by the retired

employee's health insurance contracted for under ORS 238.410, and the employee retired on or after September 29, 1991.

(c) "Qualifying service" means creditable service in the system and any periods of employment with an employer participating in the system required of the employee before becoming a member of the system.

(d) "System" means the Public Employees Retirement System.

(2) Of the monthly cost of coverage for an eligible retired state employee under a health care insurance contract entered into under ORS 238.410, an amount as determined under subsection (3) of this section shall be paid from the Retiree Health Insurance Premium Account established by subsection (4) of this section, and any monthly cost in excess of the amount so determined shall be paid by the eligible retired state employee in the manner provided in ORS 238.410 (4). Any amount paid under this subsection shall be exempt from all state, county and municipal taxes imposed on the eligible retired member.

(3) On or before January 1 of each year, the Public Employees Retirement Board shall calculate the average difference between the health insurance premiums paid by retired state employees under contracts entered into by the board under ORS 238.410 and the health insurance premiums paid by state employees who are not retired [*under contracts entered into by the Public Employees' Benefit Board*]. For the purposes of subsection (2) of this section, an eligible retired state employee shall be entitled to receive toward the monthly cost of coverage under a health insurance contract entered into under ORS 238.410:

(a) For an eligible retired state employee with eight years or more of qualifying service in the system, but less than 10 years of qualifying service in the system, 50 percent of the amount calculated by the board under this subsection.

(b) For an eligible retired state employee with 10 years or more of qualifying service in the system, but less than 15 years of qualifying service in the system, 60 percent of the amount calculated by the board under this subsection.

(c) For an eligible retired state employee with 15 years or more of qualifying service in the system, but less than 20 years of qualifying service in the system, 70 percent of the amount calculated by the board under this subsection.

(d) For an eligible retired state employee with 20 years or more of qualifying service in the system, but less than 25 years of qualifying service in the system, 80 percent of the amount calculated by the board under this subsection.

(e) For an eligible retired state employee with 25 years or more of qualifying service in the system, but less than 30 years of qualifying service in the system, 90 percent of the amount calculated by the board under this subsection.

(f) For an eligible retired state employee with 30 years or more of qualifying service in the system, 100 percent of the amount calculated by the board under this subsection.

(4) Pursuant to section 401(h) of the Internal Revenue Code, the Retiree Health Insurance Premium Account is established within the Public Employees Retirement Fund, separate and distinct from the General Fund. Interest earned by the account shall be credited to the account. All moneys in the account are continuously appropriated to the Public Employees Retirement Board and may be used only to pay costs of health care insurance contract coverage under subsection (2) of this section, paying the administrative costs incurred by the board under this section and investment of moneys in the account under any law of this state specifically authorizing that investment.

(5) The Retiree Health Insurance Premium Account shall be funded by employer contributions.

The state shall transmit to the board those amounts the board determines to be actuarially necessary to fund the liabilities of the account. The level of employer contributions shall be established by the board using the same actuarial assumptions it uses to determine employer contribution rates to the Public Employees Retirement Fund. The amounts shall be transmitted at the same time and in the same manner as contributions for pension benefits are transmitted under ORS 238.225.

(6) The Public Employees Retirement Board shall, by rule, establish a procedure for calculating the average difference between the health insurance premiums paid by retired state employees under contracts entered into by the board under ORS 238.410 and the health insurance premiums paid by state employees who are not retired [*under contracts entered into by the Public Employees' Benefit Board*].

(7) As provided in section 401(h)(5) of the Internal Revenue Code of 1986, upon satisfaction of all liabilities for providing benefits described in subsection (2) of this section, any amount remaining in the Retiree Health Insurance Premium Account shall be returned to the state.

(8) No member of the system shall have an interest in the Retiree Health Insurance Premium Account or in the benefits provided under this section.

SECTION 22. ORS 243.061 is amended to read:

243.061. (1) There is created in the [*Oregon Health Authority*] **Oregon Department of Administrative Services** the Public Employees' Benefit Board consisting of at least eight voting members and two members of the Legislative Assembly as nonvoting advisory members. Two of the voting members are ex officio members and six are appointed by the Governor. The voting members shall be:

(a) Four members representing the state as an employer and management employees, who shall be as follows:

(A) The Director of the Oregon [*Health Authority*] **Department of Administrative Services** or a designee of the director; **and**

[*(B) The Administrator of the Office for Oregon Health Policy and Research or a designee of the administrator; and*]

[*(C)*] **(B)** Two management employees appointed by the Governor from areas of state government other than the Oregon Health Authority [*or the Office for Oregon Health Policy and Research*]; and

(b) Four members appointed by the Governor and representing nonmanagement representable employees, who shall be as follows:

(A) Two persons from the largest employee representative unit;

(B) One person from the second largest employee representative unit; and

(C) One person from representable employees not represented by employee representative units described in subparagraphs (A) and (B) of this paragraph.

(2) One member of the Senate shall be appointed by the President of the Senate and one member of the House of Representatives shall be appointed by the Speaker of the House to serve as nonvoting advisory members.

(3)(a) If the governing body of a local government elects to participate in a benefit plan offered by the board, in addition to the members appointed under subsections (1) and (2) of this section, the Governor shall appoint two voting members, one of whom represents local government management and one of whom represents local government nonmanagement employees.

(b) After the appointment of members under paragraph (a) of this subsection, if the number of eligible employees of a local government or local governments enrolled in a benefit plan or plans offered by the board exceeds 25,000, the Governor shall appoint two additional voting members, one

of whom represents local government management and one of whom represents local government nonmanagement employees.

(c) After the appointment of members under paragraphs (a) and (b) of this subsection, for every additional 25,000 eligible employees of a local government or local governments enrolled in a benefit plan or plans offered by the board, the Governor shall appoint one additional voting member representing local government management and one additional voting member representing local government nonmanagement employees.

(4) A maximum of three members may be appointed to represent local government management and a maximum of three members may be appointed to represent local government nonmanagement employees.

(5) The term of office of each appointed voting member is four years, but an appointed voting member serves at the pleasure of the Governor. Before the expiration of the term of a voting member appointed by the Governor, the Governor shall appoint a successor to take office upon the date of that expiration. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(6) The appointments by the Governor of voting members of the board are subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

(7) Members of the board who are not members of the Legislative Assembly shall receive no compensation for their services, but shall be paid for their necessary and actual expenses while on official business in accordance with ORS 292.495. Members of the board who are members of the Legislative Assembly shall be paid compensation and expense reimbursement as provided in ORS 171.072, payable from funds appropriated to the Legislative Assembly.

(8) As used in this section, "benefit plan" and "local government" have the meanings given those terms in ORS 243.105.

SECTION 23. ORS 243.105 is amended to read:

243.105. As used in ORS 243.105 to 243.285, unless the context requires otherwise:

(1) "Benefit plan" includes, but is not limited to[*:*]

[*(a)*] contracts for insurance or other benefits, including [*medical, dental, vision,*] life[*,*] **and** disability [*and other health care recognized by state law*], **other than health care** and related services and supplies[*;*]**.**

[*(b) Comparable benefits for employees who rely on spiritual means of healing; and*]

[*(c) Self-insurance programs managed by the Public Employees' Benefit Board.*]

(2) "Board" means the Public Employees' Benefit Board.

(3) "Carrier" means an insurance company [*or health care service contractor*] holding a valid certificate of authority from the Director of the Department of Consumer and Business Services, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation, or a board-approved guarantor of benefit plan coverage and compensation.

(4) "District" means a common school district, a union high school district, an education service district, as defined in ORS 334.003, or a community college district, as defined in ORS 341.005.

[*(4)(a)*] **(5)(a)** "Eligible employee" means an officer or employee of a state agency**, district** or local government who elects to participate in one of the group benefit plans described in ORS [*243.135*] **243.275**. The term includes, but is not limited to, [*state*] officers and employees in the exempt, unclassified and classified service, and [*state*] officers and employees, whether or not retired,

who:

(A) Are receiving a service retirement allowance, a disability retirement allowance or a pension under the Public Employees Retirement System or are receiving a service retirement allowance, a disability retirement allowance or a pension under any other retirement or disability benefit plan or system offered by the State of Oregon for its officers and employees;

(B) Are eligible to receive a service retirement allowance under the Public Employees Retirement System and have reached earliest retirement age under ORS chapter 238;

(C) Are eligible to receive a pension under ORS 238A.100 to 238A.250, and have reached earliest retirement age as described in ORS 238A.165; or

(D) Are eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by the State of Oregon and have attained earliest retirement age under the plan or system.

(b) "Eligible employee" does not include individuals:

(A) Engaged as independent contractors;

(B) Whose periods of employment in emergency work are on an intermittent or irregular basis;

(C) Who are employed on less than half-time basis unless the individuals are employed in positions classified as job-sharing positions, unless the individuals are defined as eligible under rules of the board;

(D) Appointed under ORS 240.309;

(E) Provided sheltered employment or make-work by the state in an employment or industries program maintained for the benefit of such individuals;

(F) Provided student health care services in conjunction with their enrollment as students at a public university listed in ORS 352.002; or

(G) Who are members of a collective bargaining unit that represents police officers or firefighters.

[*(5)*] **(6)** "Family member" means an eligible employee's spouse and any unmarried child or stepchild within age limits and other conditions imposed by the board with regard to unmarried children or stepchildren.

[*(6)*] **(7)** "Local government" means any city, county or special district in this state or any intergovernmental entity created under ORS chapter 190.

[*(7)*] **(8)** "Payroll disbursing officer" means the officer or official authorized to disburse moneys in payment of salaries and wages of employees of a state agency or local government.

[*(8)*] **(9)** "Premium" means the monthly or other periodic charge for a benefit plan.

[*(9)*] **(10)** "State agency" means every state officer, board, commission, department or other activity of state government.

SECTION 24. ORS 243.125 is amended to read:

243.125. (1) The Public Employees' Benefit Board shall prescribe rules for the conduct of its business [*and for carrying out ORS 243.256*]. The board shall study all matters connected with the providing of adequate benefit plan coverage for eligible employees on the best basis possible with relation both to the welfare of the employees and to the state and local governments. The board shall design benefits, devise specifications, analyze carrier responses to advertisements for bids and decide on the award of contracts. Contracts shall be signed by the chairperson on behalf of the board.

(2) In carrying out its duties under subsection (1) of this section, the goal of the board shall be to provide [*a*] high quality [*plan of health and other benefits*] **benefit plans** for employees at a cost

affordable to both the employer and the employees.

(3) Subject to ORS chapter 183, the board may make rules not inconsistent with ORS 243.105 to 243.285 and 292.051 to determine the terms and conditions of eligible employee participation and coverage.

[*(4) The board shall prepare specifications, invite bids and do acts necessary to award contracts for health benefit plan and dental benefit plan coverage of eligible employees in accordance with the criteria set forth in ORS 243.135 (1).*]

[*(5)*] The executive director of the board shall report to the Director of the Oregon [*Health Authority*] **Department of Administrative Services**.

[*(6)*] **(4)** The board may retain consultants, brokers or other advisory personnel when necessary and, subject to the State Personnel Relations Law, shall employ such personnel as are required to perform the functions of the board.

SECTION 25. ORS 243.129 is amended to read:

243.129. (1) The governing body of a local government may elect to participate in a benefit plan offered by the Public Employees' Benefit Board.

(2) The decision of the governing body of a local government to participate in a benefit plan offered by the board is in the discretion of the governing body of the local government and is a permissive subject of collective bargaining.

[*(3) If the governing body of a local government elects to offer a benefit plan through the board, the governing body may elect one time only to provide alternative group health and welfare insurance benefit plans to eligible employees if:*]

[*(a) The alternative benefit plan is offered through the health insurance exchange under ORS 741.310 (1)(b); and*]

[*(b) The participation of the local government is not precluded under federal law on or after January 1, 2017.*]

SECTION 26. ORS 243.145 is amended to read:

243.145. (1) The Public Employees' Benefit Board shall have authority to employ whatever means are reasonably necessary to carry out the purposes of ORS 243.105 to 243.285 and 292.051. The board's authority includes, but is not limited to, the authority to self-insure and to seek clarification, amendment, modification, suspension or termination of any agreement or contract that in the board's judgment requires such action.

(2) Upon providing specific notice in writing to the carrier, the affected employee organization or organizations, the [*Oregon Health Authority*] **Oregon Department of Administrative Services** and affected eligible employees, and after affording opportunity for a public hearing upon the issues that may be involved, the board may enter an order withdrawing approval of any benefit plan. Thirty days after entry of the order, the board shall terminate all withholding authorizations of eligible employees and terminate all board-approved participation in the plan.

(3) The board by order may terminate the participation of any state agency**, district** or local government if within three months the state agency or local government fails to perform any action required by ORS 243.105 to 243.285 and 292.051 or by board rule.

SECTION 27. ORS 243.185 is amended to read:

243.185. Subject to legislative or Emergency Board approval of budgetary authorization for operation of the Public Employees' Benefit Board and its administration of the [*health benefit plans and other*] duties under ORS 243.105 to 243.285 and 292.051, an amount not to exceed two percent of the employer and employee contributions shall be forwarded by each payroll disbursing officer to the

board and deposited by it in the State Treasury to the credit of the Public Employees' Benefit Account to meet administrative and other costs authorized by ORS 243.105 to 243.285 and 292.051. The board shall take action to ensure that the balance in the account does not exceed five percent of the monthly total of employer and employee contributions for more than 120 days.

SECTION 28. ORS 243.221 is amended to read:

243.221. (1) In addition to the powers and duties otherwise provided by law to provide employee benefits, the Public Employees' Benefit Board may provide, administer and maintain flexible benefit plans under which eligible employees may choose among taxable and nontaxable benefits as provided in the federal Internal Revenue Code.

(2) In providing flexible benefit plans, the board may offer:

[*(a) Health or dental benefits as provided in ORS 243.125 and 243.135.*]

[*(b)*] **(a)** [*Other*] Insurance benefits as provided in ORS 243.275.

[*(c)*] **(b)** Dependent care assistance as provided in ORS 243.550.

[*(d)*] **(c)** Expense reimbursement as provided in ORS 243.560.

[*(e)*] **(d)** Any other benefit that may be excluded from an employee's gross income under the federal Internal Revenue Code.

(f) Any part or all of the state or local government contribution for employee benefits in cash to the employee.

(3) In developing flexible benefit plans under this section, the board shall design the plan on the best basis possible with relation to the welfare of employees, the state and the local governments.

EXPANSION OF OREGON PRESCRIPTION DRUG PROGRAM

SECTION 29. ORS 414.312 is amended to read:

414.312. (1) As used in ORS 414.312 to 414.318:

(a) "Coordinated care organization" has the meaning given that term in ORS 414.025.

[*(a)*] **(b)** "Pharmacy benefit manager" means an entity that negotiates and executes contracts with pharmacies, manages preferred drug lists, negotiates rebates with prescription drug manufacturers and serves as an intermediary between the Oregon Prescription Drug Program, prescription drug manufacturers and pharmacies.

[*(b)*] **(c)** "Prescription drug claims processor" means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the Oregon Prescription Drug Program and processes related payments to pharmacies.

[*(c)*] **(d)** "Program price" means the reimbursement rates and prescription drug prices established by the administrator of the Oregon Prescription Drug Program.

(2) The Oregon Prescription Drug Program is established in the Oregon Health Authority. The purpose of the program is to:

(a) Purchase prescription drugs, replenish prescription drugs dispensed or reimburse pharmacies for prescription drugs in order to receive discounted prices and rebates;

(b) Make prescription drugs available at the lowest possible cost to participants in the program as a means to promote health;

(c) Maintain a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices; and

(d) Promote health through the purchase and provision of discount prescription drugs and co-

ordination of comprehensive prescription benefit services for eligible entities and members.

(3) The Director of the Oregon Health Authority shall appoint an administrator of the Oregon Prescription Drug Program. The administrator may:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers or group purchasing organizations;

(b) Purchase prescription drugs on behalf of individuals and entities that participate in the program;

(c) Contract with a prescription drug claims processor to adjudicate pharmacy claims and transmit program prices to pharmacies;

(d) Determine program prices and reimburse or replenish pharmacies for prescription drugs dispensed or transferred;

(e) Adopt and implement a preferred drug list for the program;

(f) Develop a system for allocating and distributing the operational costs of the program and any rebates obtained to participants of the program; and

(g) Cooperate with other states or regional consortia in the bulk purchase of prescription drugs.

(4) The following individuals or entities [*may*] **shall** participate in the program:

[*(a) Public Employees' Benefit Board, Oregon Educators Benefit Board and Public Employees Retirement System;*]

[*(b) Local governments as defined in ORS 174.116 and special government bodies as defined in ORS 174.117 that directly or indirectly purchase prescription drugs;*]

(a) Members enrolled in a coordinated care organization;

[*(c)*] **(b)** Oregon Health and Science University established under ORS 353.020;

[*(d)*] **(c)** State agencies that directly or indirectly purchase prescription drugs, including agencies that dispense prescription drugs directly to persons in state-operated facilities;

(5) The following individuals or entities may participate in the program:

[*(e)*] **(a)** Residents of this state who lack or are underinsured for prescription drug coverage;

[*(f)*] **(b)** Private entities; [*and*]

[*(g)*] **(c)** Labor organizations**; and**

(d) Individuals who are eligible for Medicare Part D prescription drug coverage.

[*(5)*] **(6)** The administrator may establish different program prices for pharmacies in rural areas to maintain statewide access to the program.

[*(6)*] **(7)** The administrator may establish the terms and conditions for a pharmacy to enroll in the program. A licensed pharmacy that is willing to accept the terms and conditions established by the administrator may apply to enroll in the program.

[*(7)*] **(8)** Except as provided in subsection [*(8)*] **(9)** of this section, the administrator may not:

(a) Contract with a pharmacy benefit manager;

(b) Establish a state-managed wholesale or retail drug distribution or dispensing system; or

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program.

[*(8)*] **(9)** The administrator shall contract with one or more entities to perform any of the functions of the program, including but not limited to:

(a) Contracting with a pharmacy benefit manager and directly or indirectly with such pharmacy networks as the administrator considers necessary to maintain statewide access to the program.

(b) Negotiating with prescription drug manufacturers on behalf of the administrator.

[*(9) Notwithstanding subsection (4)(e) of this section, individuals who are eligible for Medicare Part*

D prescription drug coverage may participate in the program.]

(10) The program may contract with vendors as necessary to utilize discount purchasing programs, including but not limited to group purchasing organizations established to meet the criteria of the Nonprofit Institutions Act, 15 U.S.C. 13c, or that are exempt under the Robinson-Patman Act, 15 U.S.C. 13.

SECTION 30. ORS 414.314 is amended to read:

414.314. (1) An individual or entity described in ORS 414.312 [*(4)*] **(5)** may apply to participate in the Oregon Prescription Drug Program. Participants shall apply on an application provided by the Oregon Health Authority. The authority may charge participants a nominal fee to participate in the program. The authority shall issue a prescription drug identification card to participants of the program.

(2) The authority shall provide a mechanism to calculate and transmit the program prices for prescription drugs to a pharmacy. The pharmacy shall charge the participant the program price for a prescription drug.

(3) A pharmacy may charge the participant the professional dispensing fee set by the authority.

(4) Prescription drug identification cards issued under this section must contain the information necessary for proper claims adjudication or transmission of price data.

TEMPORARY CHANGE TO HOSPITAL REIMBURSEMENT BY PUBLIC EMPLOYEES' BENEFIT BOARD AND OREGON EDUCATORS BENEFIT BOARD

SECTION 31. ORS 243.256 is amended to read:

243.256. (1) A hospital that provides services or supplies under a benefit plan offered by the Public Employees' Benefit Board shall be reimbursed [*using the methodology prescribed by the Oregon Health Authority under ORS 442.392*] **in an amount that does not exceed 180 percent of the amount paid by Medicare for the service or supply** and may not be reimbursed for each service or supply provided.

(2) This section applies to hospital payments made by a carrier under a contract with the board and to hospital payments made under a self-insurance program administered by a third party administrator on behalf of the board.

(3) This section does not apply to reimbursements paid by a carrier or third party administrator to a hospital that is not subject to the methodology prescribed by the authority under ORS 442.392.

SECTION 32. ORS 243.879 is amended to read:

243.879. (1) A hospital that provides services or supplies under a benefit plan offered by the Oregon Educators Benefit Board shall be reimbursed [*using the methodology prescribed by the Oregon Health Authority under ORS 442.392*] **in an amount that does not exceed 180 percent of the amount paid by Medicare for the service or supply** and may not be reimbursed for each service or supply provided.

(2) This section applies to hospital payments made by a carrier under a contract with the board and to hospital payments made under a self-insurance program administered by a third party administrator on behalf of the board.

(3) This section does not apply to reimbursements paid by a carrier or third party administrator to a hospital that is not subject to the methodology prescribed by the authority under ORS 442.392.

CONFORMING AMENDMENTS

SECTION 33. ORS 192.556 is amended to read:

192.556. As used in ORS 192.553 to 192.581:

(1) "Authorization" means a document written in plain language that contains at least the following:

(a) A description of the information to be used or disclosed that identifies the information in a specific and meaningful way;

(b) The name or other specific identification of the person or persons authorized to make the requested use or disclosure;

(c) The name or other specific identification of the person or persons to whom the covered entity may make the requested use or disclosure;

(d) A description of each purpose of the requested use or disclosure, including but not limited to a statement that the use or disclosure is at the request of the individual;

(e) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;

(f) The signature of the individual or personal representative of the individual and the date;

(g) A description of the authority of the personal representative, if applicable; and

(h) Statements adequate to place the individual on notice of the following:

(A) The individual's right to revoke the authorization in writing;

(B) The exceptions to the right to revoke the authorization;

(C) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization; and

(D) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected.

(2) "Covered entity" means:

(a) A state health plan;

(b) A health insurer;

(c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.553 to 192.581; [*or*]

(d) A health care clearinghouse**; or**

(e) A coordinated care organization as defined in ORS 414.025.

(3) "Health care" means care, services or supplies related to the health of an individual.

(4) "Health care operations" includes but is not limited to:

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

(c) Reviewing the competence, qualifications or performance of health care providers or health insurers;

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating deidentified information; and

(j) Fundraising.

(5) "Health care provider" includes but is not limited to:

(a) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

(b) A physician or physician assistant licensed under ORS chapter 677, an acupuncturist licensed under ORS 677.759 or an employee of the physician, physician assistant or acupuncturist;

(c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

(e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;

(f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;

(g) An emergency medical services provider licensed under ORS chapter 682;

(h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

(o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory care practitioner;

(p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the polysomnographic technologist;

(q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

(r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;

(s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;

(t) A health care facility as defined in ORS 442.015;

(u) A home health agency as defined in ORS 443.014;

(v) A hospice program as defined in ORS 443.850;

(w) A clinical laboratory as defined in ORS 438.010;

(x) A pharmacy as defined in ORS 689.005;

(y) A diabetes self-management program as defined in ORS 743A.184; and

(z) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(6) "Health information" means any oral or written information in any form or medium that:

(a) Is created or received by a covered entity, a public health authority, an employer, a life insurer, a school, a university or a health care provider that is not a covered entity; and

(b) Relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(7) "Health insurer" means:

(a) An insurer as defined in ORS 731.106 who offers:

(A) A health benefit plan as defined in ORS 743B.005;

(B) A short term health insurance policy, the duration of which does not exceed six months including renewals;

(C) A student health insurance policy;

(D) A Medicare supplemental policy; or

(E) A dental only policy.

(b) The Oregon Medical Insurance Pool operated by the Oregon Medical Insurance Pool Board under ORS 735.600 to 735.650.

(8) "Individually identifiable health information" means any oral or written health information in any form or medium that is:

(a) Created or received by a covered entity, an employer or a health care provider that is not a covered entity; and

(b) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(9) "Payment" includes but is not limited to:

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(10) "Personal representative" includes but is not limited to:

(a) A person appointed as a guardian under ORS 125.305, 419B.372, 419C.481 or 419C.555 with authority to make medical and health care decisions;

(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or a representative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment decisions;

(c) A person appointed as a personal representative under ORS chapter 113; and

(d) A person described in ORS 192.573.

(11)(a) "Protected health information" means individually identifiable health information that is maintained or transmitted in any form of electronic or other medium by a covered entity.

(b) "Protected health information" does not mean individually identifiable health information in:

(A) Education records covered by the federal Family Educational Rights and Privacy Act (20 U.S.C. 1232g);

(B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

(C) Employment records held by a covered entity in its role as employer.

(12) "State health plan" means:

(a) Medical assistance as defined in ORS 414.025;

(b) The Health Care for All Oregon Children program; or

(c) Any medical assistance or premium assistance program operated by the Oregon Health Authority.

(13) "Treatment" includes but is not limited to:

(a) The provision, coordination or management of health care; and

(b) Consultations and referrals between health care providers.

SECTION 34. ORS 192.556, as amended by section 30, chapter 698, Oregon Laws 2013, is amended to read:

192.556. As used in ORS 192.553 to 192.581:

(1) "Authorization" means a document written in plain language that contains at least the following:

(a) A description of the information to be used or disclosed that identifies the information in a specific and meaningful way;

(b) The name or other specific identification of the person or persons authorized to make the requested use or disclosure;

(c) The name or other specific identification of the person or persons to whom the covered entity may make the requested use or disclosure;

(d) A description of each purpose of the requested use or disclosure, including but not limited to a statement that the use or disclosure is at the request of the individual;

(e) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;

(f) The signature of the individual or personal representative of the individual and the date;

(g) A description of the authority of the personal representative, if applicable; and

(h) Statements adequate to place the individual on notice of the following:

(A) The individual's right to revoke the authorization in writing;

(B) The exceptions to the right to revoke the authorization;

(C) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization; and

(D) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected.

(2) "Covered entity" means:

(a) A state health plan;

(b) A health insurer;

(c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.553 to 192.581; [*or*]

(d) A health care clearinghouse**; or**

(e) A coordinated care organization as defined in ORS 414.025.

(3) "Health care" means care, services or supplies related to the health of an individual.

(4) "Health care operations" includes but is not limited to:

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

(c) Reviewing the competence, qualifications or performance of health care providers or health insurers;

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating deidentified information; and

(j) Fundraising.

(5) "Health care provider" includes but is not limited to:

(a) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

(b) A physician or physician assistant licensed under ORS chapter 677, an acupuncturist licensed under ORS 677.759 or an employee of the physician, physician assistant or acupuncturist;

(c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

(e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;

(f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;

(g) An emergency medical services provider licensed under ORS chapter 682;

(h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

(o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory care practitioner;

(p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the polysomnographic technologist;

(q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

(r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;

(s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;

(t) A health care facility as defined in ORS 442.015;

(u) A home health agency as defined in ORS 443.014;

(v) A hospice program as defined in ORS 443.850;

(w) A clinical laboratory as defined in ORS 438.010;

(x) A pharmacy as defined in ORS 689.005;

(y) A diabetes self-management program as defined in ORS 743A.184; and

(z) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(6) "Health information" means any oral or written information in any form or medium that:

(a) Is created or received by a covered entity, a public health authority, an employer, a life insurer, a school, a university or a health care provider that is not a covered entity; and

(b) Relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(7) "Health insurer" means an insurer as defined in ORS 731.106 who offers:

(a) A health benefit plan as defined in ORS 743B.005;

(b) A short term health insurance policy, the duration of which does not exceed six months including renewals;

(c) A student health insurance policy;

(d) A Medicare supplemental policy; or

(e) A dental only policy.

(8) "Individually identifiable health information" means any oral or written health information in any form or medium that is:

(a) Created or received by a covered entity, an employer or a health care provider that is not a covered entity; and

(b) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(9) "Payment" includes but is not limited to:

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(10) "Personal representative" includes but is not limited to:

(a) A person appointed as a guardian under ORS 125.305, 419B.372, 419C.481 or 419C.555 with authority to make medical and health care decisions;

(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or a representative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment decisions;

(c) A person appointed as a personal representative under ORS chapter 113; and

(d) A person described in ORS 192.573.

(11)(a) "Protected health information" means individually identifiable health information that is maintained or transmitted in any form of electronic or other medium by a covered entity.

(b) "Protected health information" does not mean individually identifiable health information in:

(A) Education records covered by the federal Family Educational Rights and Privacy Act (20 U.S.C. 1232g);

(B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

(C) Employment records held by a covered entity in its role as employer.

(12) "State health plan" means:

(a) Medical assistance as defined in ORS 414.025;

(b) The Health Care for All Oregon Children program; or

(c) Any medical assistance or premium assistance program operated by the Oregon Health Authority.

(13) "Treatment" includes but is not limited to:

(a) The provision, coordination or management of health care; and

(b) Consultations and referrals between health care providers.

SECTION 35. ORS 196.165 is amended to read:

196.165. (1) The Columbia River Gorge Commission established under ORS 196.150 may designate its employees as employees and the commission as an employer subject to the Oregon Public Employees Retirement System under ORS chapters 238 and 238A or as an employer and employees subject to a retirement system provided by the State of Washington under the laws of the State of Washington.

(2) The commission may designate its employees as employees eligible under benefit plans provided under ORS 243.105 to 243.285 **and for enrollment in a coordinated care organization as provided in section 3 of this 2017 Act,** or under benefit plans provided under the laws of the State of Washington.

SECTION 36. ORS 240.309 is amended to read:

240.309. (1) Temporary employment shall be used for the purpose of meeting emergency, nonrecurring or short-term workload needs of the state.

(2) A temporary employee may be given a nonstatus appointment without open competition and consideration only for the purposes enumerated in this section. Temporary appointments shall not be used to defeat the open competition and consideration system.

(3) A temporary employee may not be employed in a permanent, seasonal, intermittent or limited duration position except to replace an employee during an approved leave period.

(4) Employment of a temporary employee for the same workload need, other than for leave, may not exceed six calendar months. The decision to extend the period of employment may be delegated by the Personnel Division of the Oregon Department of Administrative Services to other state agencies. Approval to extend shall be allowed only upon an appointing authority's finding that the original emergency continues to exist and that there is no other reasonable means to meet the

emergency. Agency actions under this subsection are subject to post-audit review by the Oregon Department of Administrative Services as provided in ORS 240.311.

(5) Employment of a temporary employee for different workload needs shall not exceed the equivalent of six calendar months in a 12-month period.

(6) A temporary employee shall not be denied permanent work because of the temporary status. Temporary service shall not be used as any portion of a required trial service period.

(7) The Personnel Division of the Oregon Department of Administrative Services shall report the use of temporary employees, by agency, once every six months, including the duration and reason for use or extensions, if any, of temporary appointments. The reports shall be made available upon request to interested parties, including employee organizations. If any interested party alleges misuse of temporary employees, the division shall investigate, report its findings and take appropriate action.

(8) The Department of Justice may use temporary status appointments for student law clerks for a period not to exceed 24 months.

(9) The chief administrative law judge of the Office of Administrative Hearings may use temporary status appointments for student law clerks for a period not to exceed 24 months. Student law clerks appointed under this subsection may not act as administrative law judges or conduct hearings for the Office of Administrative Hearings.

(10) The Public Utility Commission may use temporary status appointments for student law clerks for a period not to exceed 24 months.

(11) A state agency may use temporary status appointments for a period not to exceed 48 months for student interns who are enrolled in high school or who are under 19 years of age and are training to receive a General Educational Development (GED) certificate. Student interns are not eligible for benefits under ORS 243.105 to 243.285 **or eligible to enroll in a coordinated care organization under section 3 of this 2017 Act**.

SECTION 37. ORS 279A.025 is amended to read:

279A.025. (1) Except as provided in subsections (2) to (4) of this section, the Public Contracting Code applies to all public contracting.

(2) The Public Contracting Code does not apply to:

(a) Contracts between a contracting agency and:

(A) Another contracting agency;

(B) The Oregon Health and Science University;

(C) A public university listed in ORS 352.002;

(D) The Oregon State Bar;

(E) A governmental body of another state;

(F) The federal government;

(G) An American Indian tribe or an agency of an American Indian tribe;

(H) A nation, or a governmental body in a nation, other than the United States; or

(I) An intergovernmental entity formed between or among:

(i) Governmental bodies of this or another state;

(ii) The federal government;

(iii) An American Indian tribe or an agency of an American Indian tribe;

(iv) A nation other than the United States; or

(v) A governmental body in a nation other than the United States;

(b) Agreements authorized by ORS chapter 190 or by a statute, charter provision, ordinance or

other authority for establishing agreements between or among governmental bodies or agencies or tribal governing bodies or agencies;

(c) Insurance and service contracts as provided for under ORS 414.115, 414.125, 414.135 and 414.145 for purposes of source selection;

(d) Grants;

(e) Contracts for professional or expert witnesses or consultants to provide services or testimony relating to existing or potential litigation or legal matters in which a public body is or may become interested;

(f) Acquisitions or disposals of real property or interest in real property;

(g) Sole-source expenditures when rates are set by law or ordinance for purposes of source selection;

(h) Contracts for the procurement or distribution of textbooks;

(i) Procurements by a contracting agency from an Oregon Corrections Enterprises program;

(j) The procurement, transportation or distribution of distilled liquor, as defined in ORS 471.001, or the appointment of agents under ORS 471.750 by the Oregon Liquor Control Commission;

(k) Contracts entered into under ORS chapter 180 between the Attorney General and private counsel or special legal assistants;

(L) Contracts for the sale of timber from lands owned or managed by the State Board of Forestry and the State Forestry Department;

(m) Contracts for activities necessary or convenient for the sale of timber under paragraph (L) of this subsection, either separately from or in conjunction with contracts for the sale of timber, including but not limited to activities such as timber harvesting and sorting, transporting, gravel pit development or operation, and road construction, maintenance or improvement;

(n) Contracts for forest protection or forest related activities, as described in ORS 477.406, by the State Forester or the State Board of Forestry;

(o) Contracts entered into by the Housing and Community Services Department in exercising the department's duties prescribed in ORS chapters 456 and 458, except that the department's public contracting for goods and services is subject to ORS chapter 279B;

(p) Contracts entered into by the State Treasurer in exercising the powers of that office prescribed in ORS 178.010 to 178.100 and ORS chapters 286A, 287A, 289, 293, 294 and 295, including but not limited to investment contracts and agreements, banking services, clearing house services and collateralization agreements, bond documents, certificates of participation and other debt repayment agreements, and any associated contracts, agreements and documents, regardless of whether the obligations that the contracts, agreements or documents establish are general, special or limited, except that the State Treasurer's public contracting for goods and services is subject to ORS chapter 279B;

(q) Contracts, agreements or other documents entered into, issued or established in connection with:

(A) The issuance of obligations, as defined in ORS 286A.100 and 287A.310, of a public body;

(B) The making of program loans and similar extensions or advances of funds, aid or assistance by a public body to a public or private body for the purpose of carrying out, promoting or sustaining activities or programs authorized by law; or

(C) The investment of funds by a public body as authorized by law, and other financial transactions of a public body that by their character cannot practically be established under the competitive contractor selection procedures of ORS 279B.050 to 279B.085;

(r) Contracts for employee benefit plans as provided in ORS 243.105 (1), [*243.125 (4),*] 243.221, 243.275, 243.291, 243.303 and 243.565; **or**

[*(s) Contracts for employee benefit plans as provided in ORS 243.860 to 243.886; or*]

[*(t)*] **(s)** Any other public contracting of a public body specifically exempted from the code by another provision of law.

(3) The Public Contracting Code does not apply to the contracting activities of:

(a) The Oregon State Lottery Commission;

(b) The legislative department;

(c) The judicial department;

(d) Semi-independent state agencies listed in ORS 182.454, except as provided in ORS 279.835 to 279.855 and 279A.250 to 279A.290;

(e) Oregon Corrections Enterprises;

(f) The Oregon Film and Video Office, except as provided in ORS 279A.100 and 279A.250 to 279A.290;

(g) The Travel Information Council, except as provided in ORS 279A.250 to 279A.290;

(h) The Oregon 529 Savings Network and the Oregon 529 Savings Board;

(i) The Oregon Innovation Council;

(j) The Oregon Utility Notification Center; or

(k) Any other public body specifically exempted from the code by another provision of law.

(4) ORS 279A.200 to 279A.225 and 279B.050 to 279B.085 do not apply to contracts made with qualified nonprofit agencies providing employment opportunities for individuals with disabilities under ORS 279.835 to 279.855.

SECTION 38. ORS 279A.025, as amended by section 37 of this 2017 Act, is amended to read:

279A.025. (1) Except as provided in subsections (2) to (4) of this section, the Public Contracting Code applies to all public contracting.

(2) The Public Contracting Code does not apply to:

(a) Contracts between a contracting agency and:

(A) Another contracting agency;

(B) The Oregon Health and Science University;

(C) A public university listed in ORS 352.002;

(D) The Oregon State Bar;

(E) A governmental body of another state;

(F) The federal government;

(G) An American Indian tribe or an agency of an American Indian tribe;

(H) A nation, or a governmental body in a nation, other than the United States; or

(I) An intergovernmental entity formed between or among:

(i) Governmental bodies of this or another state;

(ii) The federal government;

(iii) An American Indian tribe or an agency of an American Indian tribe;

(iv) A nation other than the United States; or

(v) A governmental body in a nation other than the United States;

(b) Agreements authorized by ORS chapter 190 or by a statute, charter provision, ordinance or other authority for establishing agreements between or among governmental bodies or agencies or tribal governing bodies or agencies;

(c) Insurance and service contracts as provided for under ORS 414.115, 414.125, 414.135 and

414.145 for purposes of source selection;

(d) Grants;

(e) Contracts for professional or expert witnesses or consultants to provide services or testimony relating to existing or potential litigation or legal matters in which a public body is or may become interested;

(f) Acquisitions or disposals of real property or interest in real property;

(g) Sole-source expenditures when rates are set by law or ordinance for purposes of source selection;

(h) Contracts for the procurement or distribution of textbooks;

(i) Procurements by a contracting agency from an Oregon Corrections Enterprises program;

(j) The procurement, transportation or distribution of distilled liquor, as defined in ORS 471.001, or the appointment of agents under ORS 471.750 by the Oregon Liquor Control Commission;

(k) Contracts entered into under ORS chapter 180 between the Attorney General and private counsel or special legal assistants;

(L) Contracts for the sale of timber from lands owned or managed by the State Board of Forestry and the State Forestry Department;

(m) Contracts for activities necessary or convenient for the sale of timber under paragraph (L) of this subsection, either separately from or in conjunction with contracts for the sale of timber, including but not limited to activities such as timber harvesting and sorting, transporting, gravel pit development or operation, and road construction, maintenance or improvement;

(n) Contracts for forest protection or forest related activities, as described in ORS 477.406, by the State Forester or the State Board of Forestry;

(o) Contracts entered into by the Housing and Community Services Department in exercising the department's duties prescribed in ORS chapters 456 and 458, except that the department's public contracting for goods and services is subject to ORS chapter 279B;

(p) Contracts entered into by the State Treasurer in exercising the powers of that office prescribed in ORS 178.010 to 178.100 and ORS chapters 286A, 287A, 289, 293, 294 and 295, including but not limited to investment contracts and agreements, banking services, clearing house services and collateralization agreements, bond documents, certificates of participation and other debt repayment agreements, and any associated contracts, agreements and documents, regardless of whether the obligations that the contracts, agreements or documents establish are general, special or limited, except that the State Treasurer's public contracting for goods and services is subject to ORS chapter 279B;

(q) Contracts, agreements or other documents entered into, issued or established in connection with:

(A) The issuance of obligations, as defined in ORS 286A.100 and 287A.310, of a public body;

(B) The making of program loans and similar extensions or advances of funds, aid or assistance by a public body to a public or private body for the purpose of carrying out, promoting or sustaining activities or programs authorized by law; or

(C) The investment of funds by a public body as authorized by law, and other financial transactions of a public body that by their character cannot practically be established under the competitive contractor selection procedures of ORS 279B.050 to 279B.085;

(r) Contracts for employee benefit plans as provided in ORS 243.105 (1), 243.221, 243.275, 243.291[*, 243.303*] and 243.565; or

(s) Any other public contracting of a public body specifically exempted from the code by another

provision of law.

(3) The Public Contracting Code does not apply to the contracting activities of:

(a) The Oregon State Lottery Commission;

(b) The legislative department;

(c) The judicial department;

(d) Semi-independent state agencies listed in ORS 182.454, except as provided in ORS 279.835 to 279.855 and 279A.250 to 279A.290;

(e) Oregon Corrections Enterprises;

(f) The Oregon Film and Video Office, except as provided in ORS 279A.100 and 279A.250 to 279A.290;

(g) The Travel Information Council, except as provided in ORS 279A.250 to 279A.290;

(h) The Oregon 529 Savings Network and the Oregon 529 Savings Board;

(i) The Oregon Innovation Council;

(j) The Oregon Utility Notification Center; or

(k) Any other public body specifically exempted from the code by another provision of law.

(4) ORS 279A.200 to 279A.225 and 279B.050 to 279B.085 do not apply to contracts made with qualified nonprofit agencies providing employment opportunities for individuals with disabilities under ORS 279.835 to 279.855.

SECTION 39. ORS 346.565 is amended to read:

346.565. (1) A business enterprise manager who is blind, as described under ORS 346.510 to 346.570, or a person who is blind who is an employee of a private nonprofit Oregon corporation established and authorized by the Commission for the Blind to provide employment to persons who are blind may [*participate in a health benefit plan available to state employees pursuant to ORS 243.105 to 243.285*] **enroll in a coordinated care organization as provided in section 3 of this 2017 Act** at the expense of the manager or employee.

(2) A business enterprise manager who is blind, as described under ORS 346.510 to 346.570, may participate in state deferred compensation plan established under ORS 243.401 to 243.507, contingent on participation not affecting the tax exempt status of other contributions to the deferred compensation plan.

(3) For the purposes of subsections (1) and (2) of this section, such managers and employees shall be considered eligible state employees.

SECTION 40. ORS 413.011, as amended by section 6, chapter 389, Oregon Laws 2015, is amended to read:

413.011. (1) The duties of the Oregon Health Policy Board are to:

(a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS 413.032 and all of the authority's departmental divisions.

(b) Develop and submit a plan to the Legislative Assembly by December 31, 2010, to provide and fund access to affordable, quality health care for all Oregonians by 2015.

(c) Develop a program to provide health insurance premium assistance to all low and moderate income individuals who are legal residents of Oregon.

(d) Publish health outcome and quality measure data collected by the Oregon Health Authority at aggregate levels that do not disclose information otherwise protected by law. The information published must report, for each coordinated care organization and each health benefit plan sold through the health insurance exchange [*or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board*]:

(A) Quality measures;

(B) Costs;

(C) Health outcomes; and

(D) Other information that is necessary for members of the public to evaluate the value of health services delivered by each coordinated care organization and by each health benefit plan.

(e) Establish evidence-based clinical standards and practice guidelines that may be used by providers.

(f) Approve and monitor community-centered health initiatives described in ORS 413.032 (1)(h) that are consistent with public health goals, strategies, programs and performance standards adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and shall regularly report to the Legislative Assembly on the accomplishments and needed changes to the initiatives.

(g) Establish cost containment mechanisms to reduce health care costs.

(h) Ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by the expansion in health coverage, health care system transformations, an increasingly diverse population and an aging workforce.

(i) Work with the Oregon congressional delegation to advance the adoption of changes in federal law or policy to promote Oregon's comprehensive health reform plan.

(j) Establish a health benefit package in accordance with ORS 741.340 to be used as the baseline for all health benefit plans offered through the health insurance exchange.

(k) Investigate and report annually to the Legislative Assembly on the feasibility and advisability of future changes to the health insurance market in Oregon, including but not limited to the following:

(A) A requirement for every resident to have health insurance coverage.

(B) A payroll tax as a means to encourage employers to continue providing health insurance to their employees.

(L) Meet cost-containment goals by structuring reimbursement rates to reward comprehensive management of diseases, quality outcomes and the efficient use of resources by promoting cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations.

(m) Oversee the expenditure of moneys from the Health Care Workforce Strategic Fund to support grants to primary care providers and rural health practitioners, to increase the number of primary care educators and to support efforts to create and develop career ladder opportunities.

(n) Work with the Public Health Benefit Purchasers Committee, administrators of the medical assistance program and the Department of Corrections to identify uniform contracting standards for health benefit plans that achieve maximum quality and cost outcomes and align the contracting standards for all state programs to the greatest extent practicable.

(o) Work with the Health Information Technology Oversight Council to foster health information technology systems and practices that promote the Oregon Integrated and Coordinated Health Care Delivery System established by ORS 414.620 and align health information technology systems and practices across this state.

(2) The Oregon Health Policy Board is authorized to:

(a) Subject to the approval of the Governor, organize and reorganize the authority as the board considers necessary to properly conduct the work of the authority.

(b) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the board's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

(3) If the board or the authority is unable to perform, in whole or in part, any of the duties described in ORS 413.006 to 413.042 and 741.340 without federal approval, the authority is authorized to request, in accordance with ORS 413.072, waivers or other approval necessary to perform those duties. The authority shall implement any portions of those duties not requiring legislative authority or federal approval, to the extent practicable.

(4) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042 and 741.340 and by other statutes.

(5) The board shall consult with the Department of Consumer and Business Services in completing the tasks set forth in subsection (1)(j) and (k)(A) of this section.

SECTION 41. ORS 413.017, as amended by section 2, chapter 389, Oregon Laws 2015, is amended to read:

413.017. (1) The Oregon Health Policy Board shall establish the committees described in subsections (2) to (4) of this section.

(2)(a) The Public Health Benefit Purchasers Committee shall include individuals who purchase health care for the following:

[*(A) The Public Employees' Benefit Board.*]

[*(B) The Oregon Educators Benefit Board.*]

[*(C)*] **(A)** Trustees of the Public Employees Retirement System.

[*(D)*] **(B)** A city government.

[*(E)*] **(C)** A county government.

[*(F)*] **(D)** A special district.

[*(G)*] **(E)** Any private nonprofit organization that receives the majority of its funding from the state and requests to participate on the committee.

(b) The Public Health Benefit Purchasers Committee shall:

(A) Identify and make specific recommendations to achieve uniformity across all public health benefit plan designs based on the best available clinical evidence, recognized best practices for health promotion and disease management, demonstrated cost-effectiveness and shared demographics among the enrollees within the pools covered by the benefit plans.

(B) Develop an action plan for ongoing collaboration to implement the benefit design alignment described in subparagraph (A) of this paragraph and shall leverage purchasing to achieve benefit uniformity if practicable.

(C) Continuously review and report to the Oregon Health Policy Board on the committee's progress in aligning benefits while minimizing the cost shift to individual purchasers of insurance without shifting costs to the private sector or the health insurance exchange.

(c) The Oregon Health Policy Board shall work with the Public Health Benefit Purchasers Committee to identify uniform provisions for state and local public contracts for health benefit plans that achieve maximum quality and cost outcomes. The board shall collaborate with the committee to develop steps to implement joint contract provisions. The committee shall identify a schedule for the implementation of contract changes. The process for implementation of joint contract provisions

must include a review process to protect against unintended cost shifts to enrollees or agencies.

(3)(a) The Health Care Workforce Committee shall include individuals who have the collective expertise, knowledge and experience in a broad range of health professions, health care education and health care workforce development initiatives.

(b) The Health Care Workforce Committee shall coordinate efforts to recruit and educate health care professionals and retain a quality workforce to meet the demand that will be created by the expansion in health care coverage, system transformations and an increasingly diverse population.

(c) The Health Care Workforce Committee shall conduct an inventory of all grants and other state resources available for addressing the need to expand the health care workforce to meet the needs of Oregonians for health care.

(4)(a) The Health Plan Quality Metrics Committee shall include the following members appointed by the Governor:

(A) An individual representing the Oregon Health Authority;

[*(B) An individual representing the Oregon Educators Benefit Board;*]

[*(C) An individual representing the Public Employees' Benefit Board;*]

[*(D)*] **(B)** An individual representing the Department of Consumer and Business Services;

[*(E)*] **(C)** Two health care providers;

[*(F)*] **(D)** One individual representing hospitals;

[*(G)*] **(E)** One individual representing insurers, large employers or multiple employer welfare arrangements;

[*(H)*] **(F)** Two individuals representing health care consumers;

[*(I)*] **(G)** Two individuals representing coordinated care organizations;

[*(J)*] **(H)** One individual with expertise in health care research;

[*(K)*] **(I)** One individual with expertise in health care quality measures; and

[*(L)*] **(J)** One individual with expertise in mental health and addiction services.

(b) The committee shall work collaboratively with the [*Oregon Educators Benefit Board, the Public Employees' Benefit Board, the*] Oregon Health Authority and the Department of Consumer and Business Services to adopt health outcome and quality measures that are focused on specific goals and provide value to the state, employers, insurers, health care providers and consumers. The committee shall be the single body to align health outcome and quality measures used in this state with the requirements of health care data reporting to ensure that the measures and requirements are coordinated, evidence-based and focused on a long term statewide vision.

(c) The committee shall use a public process that includes an opportunity for public comment to identify health outcome and quality measures that may be applied to services provided by coordinated care organizations or paid for by health benefit plans sold through the health insurance exchange [*or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board*]. The Oregon Health Authority[,] **and** the Department of Consumer and Business Services[*, the Oregon Educators Benefit Board and the Public Employees' Benefit Board*] are not required to adopt all of the health outcome and quality measures identified by the committee but may not adopt any health outcome and quality measures that are different from the measures identified by the committee. The measures must take into account the recommendations of the metrics and scoring subcommittee created in ORS 414.638 and the differences in the populations served by coordinated care organizations and by commercial insurers.

(d) In identifying health outcome and quality measures, the committee shall prioritize measures that:

(A) Utilize existing state and national health outcome and quality measures, including measures adopted by the Centers for Medicare and Medicaid Services, that have been adopted or endorsed by other state or national organizations and have a relevant state or national benchmark;

(B) Given the context in which each measure is applied, are not prone to random variations based on the size of the denominator;

(C) Utilize existing data systems, to the extent practicable, for reporting the measures to minimize redundant reporting and undue burden on the state, health benefit plans and health care providers;

(D) Can be meaningfully adopted for a minimum of three years;

(E) Use a common format in the collection of the data and facilitate the public reporting of the data; and]

(F) Can be reported in a timely manner and without significant delay so that the most current and actionable data is available.

(e) The committee shall evaluate on a regular and ongoing basis the health outcome and quality measures adopted under this section.

(f) The committee may convene subcommittees to focus on gaining expertise in particular areas such as data collection, health care research and mental health and substance use disorders in order to aid the committee in the development of health outcome and quality measures. A subcommittee may include stakeholders and staff from the Oregon Health Authority, the Department of Human Services, the Department of Consumer and Business Services, the Early Learning Council or any other agency staff with the appropriate expertise in the issues addressed by the subcommittee.

(g) This subsection does not prevent the Oregon Health Authority, the Department of Consumer and Business Services[,] **or** commercial insurers[*, the Public Employees' Benefit Board or the Oregon Educators Benefit Board*] from establishing programs that provide financial incentives to providers for meeting specific health outcome and quality measures adopted by the committee.

(5) Members of the committees described in subsections (2) to (4) of this section who are not members of the Oregon Health Policy Board are not entitled to compensation but shall be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495.

SECTION 42. ORS 413.260 is amended to read:

413.260. (1) The Oregon Health Authority, in collaboration with health insurers**,** [*and*] purchasers of health plans**,** [*including the Public Employees' Benefit Board, the Oregon Educators Benefit Board and*] other members of the patient centered primary care home learning collaborative and the patient centered primary care home program advisory committee, shall:

(a) Develop, test and evaluate strategies that reward enrollees in publicly funded health plans for:

(A) Receiving care through patient centered primary care homes that meet the core attributes established in ORS 413.259;

(B) Seeking preventative and wellness services;

(C) Practicing healthy behaviors; and

(D) Effectively managing chronic diseases.

(b) Develop, test and evaluate community-based strategies that utilize community health workers to enhance the culturally competent and linguistically appropriate health services provided by patient centered primary care homes in underserved communities.

(2) The authority shall focus on patients with chronic health conditions in developing strategies under this section.

(3) The authority[*, in collaboration with the Public Employees' Benefit Board and the Oregon Educators Benefit Board,*] shall establish uniform standards for contracts with health benefit plans providing coverage to public employees to promote the provision of patient centered primary care homes, especially for enrollees with chronic medical conditions, that are consistent with the uniform quality measures established under ORS 413.259 (1)(c).

(4) The standards established under subsection (3) of this section may direct health benefit plans to provide incentives to primary care providers who serve vulnerable populations to partner with health-focused community-based organizations to provide culturally specific health promotion and disease management services.

SECTION 43. ORS 414.661 is amended to read:

414.661. (1) As used in this section:

(a) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(b) "Subcontractor" means an entity that contracts with a coordinated care organization to provide health care, dental care, behavioral health care or other services to [*medical assistance recipients enrolled in*] **members of** the coordinated care organization.

(2) The Oregon Health Authority shall conduct one external quality review of each coordinated care organization annually. The authority may contract with an external quality review organization to conduct the review.

(3) The authority shall compile a standard list of documents that the authority or contracted review organization collects from coordinated care organizations and subcontractors. When requesting information from a coordinated care organization about its subcontractors, the authority or contracted review organization shall inform the coordinated care organization of the documents on the standard list that have been collected from the coordinated care organization's subcontractors in the preceding 12-month period.

(4) The authority or a contracted review organization may not request information from a coordinated care organization that is duplicative of or redundant with information previously provided by the coordinated care organization or a subcontractor if the information was provided within the preceding 12-month period and the relevant content of the information has not changed.

(5) The authority shall provide a contracted review organization with all information about a coordinated care organization in the authority's possession as necessary for the contracted review organization to conduct the external quality review. A contracted review organization may not seek information from a coordinated care organization before first requesting the information from the authority.

(6) This section does not apply to documents requested, submitted or collected in connection with an audit for or an investigation of fraud, waste or abuse and does not:

(a) Prohibit a coordinated care organization from requesting from a subcontractor information required by law or contract;

(b) Require the authority or a contracted review organization to disclose to a coordinated care organization any information described in this section collected from a coordinated care organization or a subcontractor; or

(c) Permit the authority or a contracted review organization to disclose to a coordinated care organization confidential or proprietary information reported to the authority or contracted review organization by another coordinated care organization or a subcontractor.

SECTION 44. ORS 421.352 is amended to read:

421.352. (1) The provisions of ORS chapters 182, 183, 240, 270, 273, 276, 279A, 279B, 279C, 283, 291, 292 and 293 and ORS 35.550 to 35.575, 183.710 to 183.725, 183.745, 183.750, 184.345, 190.430, 190.490, 200.035, 236.605 to 236.640, [*243.303,*] 243.305, 243.315, 243.325 to 243.335, 243.696, 279.835 to 279.855, 282.010 to 282.150, 283.085 to 283.092 and 656.017 (2) do not apply to Oregon Corrections Enterprises.

(2) Oregon Corrections Enterprises is not subject to any provision of law enacted after December 2, 1999, that governs state agencies generally unless the provision specifically provides that it applies to Oregon Corrections Enterprises.

SECTION 45. ORS 442.396 is amended to read:

442.396. An insurer, as defined in ORS 731.106, that contracts with the Oregon Health Authority[*, including with the Public Employees' Benefit Board and the Oregon Educators Benefit Board,*] to provide health insurance coverage for state employees, educators or medical assistance recipients must annually attest, on a form and in a manner prescribed by the authority, to its compliance with ORS [*243.256, 243.879,*] 442.392 and 442.394. A contract with an insurer subject to the requirements of this section may not be renewed without the attestation required by this section.

SECTION 46. ORS 471.752 is amended to read:

471.752. (1) An agent appointed under ORS 471.750 may [*participate in a health benefit plan*] **enroll in a coordinated care organization** available to state employees pursuant to [*ORS 243.105 to 243.285*] **section 3 of this 2017 Act** at the expense of the agent and may participate in the state deferred compensation plan established under ORS 243.401 to 243.507. For such purposes, agents shall be considered eligible state employees.

(2) A person who is the surviving spouse or child of a deceased agent or the spouse or child of an agent of the Oregon Liquor Control Commission who has a disability shall be given preference in the appointment of a successor agent, if otherwise qualified, the spouse having greater preference. The experience of such applicant in the business operation of the deceased agent or the agent who has a disability shall be the primary consideration in determining the qualifications of the applicant.

SECTION 47. ORS 565.456 is amended to read:

565.456. (1) The State Fair Council is established as a public corporation and shall exercise and carry out all powers, rights and privileges that are expressly conferred upon the council, are implied by law or are incident to such powers, rights and privileges. The council is an independent public corporation with a statewide mission and purposes and without territorial boundaries. The council is a governmental entity performing governmental functions and exercising governmental powers but, except as otherwise provided by law, is not a unit of local or municipal government or a state agency for purposes of state statutes or constitutional provisions.

(2) Unless otherwise provided by law, the council is not subject to ORS chapter 182, 183, 240, 270, 273, 276, 279A, 279B, 279C, 283, 291, 292 or 293 or ORS 35.550 to 35.575, 183.710 to 183.725, 183.745, 183.750, 190.430, 190.490, 200.035, 236.605 to 236.640, [*243.303,*] 243.305, 243.315, 243.325 to 243.335, 243.696, 279.835 to 279.855, 282.010 to 282.150, 291.050 to 291.060 or 656.017 (2).

(3) The mission and purposes of the council are:

(a) To conduct a state fair to be known as the Oregon State Fair for the education and entertainment of Oregon residents and for the promotion, preservation, growth and prosperity of the industries and interests traditionally represented in state fair activities such as agriculture, stock raising, horticulture, youth group involvement in agricultural, stock-raising and horticultural activities, viticulture, manufacturing, metal fabrication, technology and artistic, creative and cultural

pursuits; and

(b) To promote Oregon tourism related to the Oregon State Fair and fairground properties and facilities, and promote and further the preservation, growth and prosperity of other industries and activities important to the state economy by conducting the Oregon State Fair and using fairground properties and facilities.

(4) To help fulfill the council's mission and purposes, the council shall encourage residents in all parts of this state to participate in or attend the Oregon State Fair. The council may take any necessary or expedient actions to ensure that fairground properties and facilities are adequate and in good repair. The council shall operate the fairground properties and facilities as an exposition center, encourage the full utilization of the properties and facilities for revenue generation and make expenditures for the construction, repair, remodeling, maintenance, insurance and other needs of the fairground properties and facilities. Subject to any limitations established under this chapter, the council may take other actions the council deems necessary or expedient to ensure the financial viability of the Oregon State Fair and the exposition center or to promote the Oregon State Fair, Oregon tourism and other industries related to fairground business operations or fairground properties and facilities.

SECTION 48. ORS 565.470 is amended to read:

565.470. (1) The State Fair Council may employ a state fair director to oversee the day-to-day carrying out of fairground business operations and the operation of fairground properties and facilities, including but not limited to the annual conducting of the Oregon State Fair, the use of fairground properties and facilities for an exposition center, the issuance of payments for construction, repair, remodeling, maintenance, insurance and other needs of fairground properties and facilities as directed by the council, the solicitation for financial support for the Oregon State Fair and fairground properties and facilities and the promotion of the Oregon State Fair and related Oregon tourism and other industries.

(2) The state fair director may employ such subordinate council employees as the director deems reasonable for the carrying out of fairground business operations and the operation of fairground properties and facilities, including but not limited to the conducting of the Oregon State Fair and the operation of fairground properties and facilities as an exposition center.

(3) The council shall determine and approve policies and procedures to further the mission and purposes of the council and shall provide oversight and guidance to the state fair director and employees of the council.

(4) The members of the council, the state fair director and the employees of the council are not state employees and are not eligible for participation in [*state employee health benefit plans*] **coordinated care organizations as provided in section 3 of this 2017 Act**, state employee deferred compensation plans or the Public Employees Retirement System. The council shall determine the compensation and benefit package for the state fair director and other employees of the council. For purposes of any laws applicable to the council as a public corporation, including but not limited to ORS 30.260 to 30.300, the members of the council, the state fair director and the employees of the council are officers and employees of a public body.

(5) The council and a state agency may enter into agreements for the state agency to provide support services to the council. Except as provided in this subsection, if a state agency provides support services to the council, the state agency must provide the support services at the rate that the state agency would charge to other state agencies for the services. The State Parks and Recreation Department may provide support services to the council at any rate mutually agreed to by the

department and the council.

(6) The council may retain private legal counsel or, notwithstanding ORS 180.060, may contract for representation by the Attorney General. If the council contracts for representation by the Attorney General, the Attorney General shall charge the council for services at the rate charged state agencies for similar services.

SECTION 49. ORS 656.247 is amended to read:

656.247. (1) Except for medical services provided to workers subject to ORS 656.245 (4)(b)(B), payment for medical services provided to a subject worker in response to an initial claim for a work-related injury or occupational disease from the date of the employer's notice or knowledge of the claim until the date the claim is accepted or denied shall be payable in accordance with subsection (4) of this section.

(2) Notwithstanding subsection (1) of this section, no payment shall be due from the insurer or self-insured employer if the insurer or self-insured employer denies the claim within 14 days of the date of the employer's notice or knowledge of the claim.

(3)(a) Disputes about whether the medical services provided to treat the claimed work-related injury or occupational disease under subsection (1) of this section are excessive, inappropriate or ineffectual or are consistent with the criteria in subsection (1) of this section shall be resolved by the Director of the Department of Consumer and Business Services. The director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327 (3) to aid in the review of such services. If a party is dissatisfied with the order of the director, the dissatisfied party may request review under ORS 656.704 within 60 days of the date of the director's order. The order of the director may be modified only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(b) Disputes about the amount of the fee or nonpayment of bills for medical treatment and services pursuant to this section shall be resolved pursuant to ORS 656.248.

(c) Except as provided in subsection (2) of this section, when a claim is settled pursuant to ORS 656.289 (4), all medical services payable under subsection (1) of this section that are provided on or before the date of denial shall be paid in accordance with subsection (4) of this section. The insurer or self-insured employer shall notify each affected service provider of the results of the settlement.

(4)(a) If the claim in which medical services are provided under subsection (1) of this section has not been accepted or denied and a health benefit plan provides benefits to the worker, the health benefit plan shall expedite preauthorizations and guarantee payment of expenses for medical services provided prior to acceptance or denial of the claim according to the terms, conditions and benefits of the plan.

(b) If the claim for which medical services are provided under subsection (1) of this section is accepted, after the claim has been accepted the insurer or self-insured employer shall pay for the medical services provided for accepted conditions, including reimbursements for medical expenses, copayments and deductibles paid by the injured worker or the health benefit plan. Payments made under this subsection are subject to the fee schedules, limitations and conditions of this chapter.

(c) If the claim for which medical services are provided under subsection (1) of this section is denied and a health benefit plan provides benefits to the worker, after the claim is denied the health benefit plan shall pay for medical services provided according to the terms, conditions and benefits of the plan.

(d) As used in this subsection, "health benefit plan" has the meaning given that term in ORS 743B.005 [*and also means self-insured benefit plans and health benefit plans offered by the Oregon*

Educators Benefit Board and the Public Employees' Benefit Board].

SECTION 50. ORS 741.300 is amended to read:

741.300. As used in ORS 741.001 to 741.540:

(1) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(2) "Essential health benefits" has the meaning given that term in ORS 731.097.

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

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

(5) "Health insurance" has the meaning given that term in ORS 731.162, excluding disability income insurance.

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

(7) "Health plan" means health insurance, a health benefit plan or health care coverage offered by an insurer.

(8) "Insurer" means an insurer as defined in ORS 731.106 that offers health insurance, a health care service contractor, a prepaid managed care health services organization or a coordinated care organization.

(9) "Insurance producer" has the meaning given that term in ORS 731.104.

(10) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025.

(11) "State program" means a program providing medical assistance, as defined in ORS 414.025[*, and any self-insured health benefit plan or health plan offered to employees by the Public Employees' Benefit Board or the Oregon Educators Benefit Board*].

(12) "Qualified health plan" means a health benefit plan available for purchase through the health insurance exchange.

(13) "Small Business Health Options Program" or "SHOP" means a health insurance exchange for small employers as described in 42 U.S.C. 18031.

SECTION 51. ORS 741.310 is amended to read:

741.310. (1)(a) Individuals and families may purchase qualified health plans through the health insurance exchange.

(b) The following groups may purchase qualified health plans through the Small Business Health Options Program:

(A) Employers with no more than 100 employees; and

(B) Districts and eligible employees of districts that are subject to [*ORS 243.886*] **section 3 of this 2017 Act**, unless their participation is precluded by federal law.

(2)(a) Only individuals who purchase health plans through the exchange may be eligible to receive premium tax credits under section 36B of the Internal Revenue Code and reduced cost-sharing under 42 U.S.C. 18071.

(b) Only employers that purchase health plans through the SHOP may be eligible to receive small employer health insurance credits under section 45R of the Internal Revenue Code.

(3) Only an insurer that has a certificate of authority to transact insurance in this state and that meets applicable federal requirements for participating in the exchange may offer a qualified health plan through the exchange. Any qualified health plan must be certified under ORS 741.002. Coordinated care organizations that do not have a certificate of authority to transact insurance may serve only medical assistance recipients through the exchange and may not offer qualified health plans.

(4)(a) The Department of Consumer and Business Services shall adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans, including requirements that a qualified health plan provide, at a minimum, essential health benefits and have acceptable consumer and provider satisfaction ratings.

(b) The department may limit the number of qualified health plans that may be offered through the exchange as long as the same limit applies to all insurers.

(5) The department shall certify as qualified a dental only health plan as permitted by federal law.

(6) The department, in collaboration with the Oregon Health Authority and the Department of Human Services, shall coordinate the application and enrollment processes for the exchange and the state medical assistance program.

(7) The Department of Consumer and Business Services may establish risk mediation programs within the exchange.

(8) The department shall establish by rule a process for certifying insurance producers to facilitate the transaction of insurance through the exchange, in accordance with federal standards and policies.

(9) The department shall ensure that an insurer charges the same premiums for plans sold through the exchange as for identical plans sold outside of the exchange.

(10) The department is authorized to enter into contracts for the performance of the department's duties, functions or operations with respect to the exchange, including but not limited to contracting with:

(a) Insurers that meet the requirements of subsections (3) and (4) of this section, to offer qualified health plans through the exchange; and

(b) Navigators, in-person assisters and application counselors certified by the department under ORS 741.002.

(11)(a) The department shall consult with stakeholders, including but not limited to representatives of school administrators, school board members[,] **and** school employees [*and the Oregon Educators Benefit Board*], regarding the plans that may be offered through the exchange to districts and eligible employees of districts under subsection (1)(b)(B) of this section and the insurers that may offer the plans.

(b) The board and the department shall each adopt rules to ensure that:

(A) Any plan offered under subsection (1)(b)(B) of this section is underwritten by an insurer using a single risk pool composed of all eligible employees who are enrolled or who will be enrolled in the plan both through the exchange and by the board; and

(B) In every plan offered under subsection (1)(b)(B) of this section, the coverage is comparable to plans offered by the board.

(12) The department is authorized to apply for and accept federal grants, other federal funds and grants from nongovernmental organizations for purposes of developing, implementing and administering the exchange. Moneys received under this subsection shall be deposited in the Health Insurance Exchange Fund.

SECTION 52. ORS 743A.058 is amended to read:

743A.058. (1) As used in this section:

(a) "Health benefit plan" [*includes:*]

[*(A) A health benefit plan as defined in ORS 743B.005; and*]

[*(B) A self-insured health plan offered through the Public Employees' Benefit Board or the Oregon*

Educators Benefit Board] **has the meaning given that term in ORS 743B.005**.

(b) "Health professional" means a person licensed, certified or registered in this state to provide health care services or supplies.

(c) "Originating site" means the physical location of the patient.

(2) A health benefit plan must provide coverage of a health service that is provided using synchronous two-way interactive video conferencing if:

(a) The plan provides coverage of the health service when provided in person by a health professional;

(b) The health service is medically necessary;

(c) The health service is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and

(d) The application and technology used to provide the health service meet all standards required by state and federal laws governing the privacy and security of protected health information.

(3) A health benefit plan may not distinguish between rural and urban originating sites in providing coverage under subsection (2) of this section.

(4) The coverage under subsection (2) of this section is subject to:

(a) The terms and conditions of the health benefit plan; and

(b) The reimbursement specified in the contract between the plan and the health professional.

(5) This section does not require a health benefit plan to reimburse a health professional:

(a) For a health service that is not a covered benefit under the plan; or

(b) Who has not contracted with the plan.

SECTION 53. ORS 743B.601, as amended by section 1, chapter 800, Oregon Laws 2015, is amended to read:

743B.601. (1) As used in this section:

(a) "Health plan" [*means:*]

[*(A) A "health benefit plan" as defined*] **has the meaning given that term** in ORS 743B.005**.**[*; and*]

[*(B) A self-insured health plan offered by the Public Employees' Benefit Board, the Oregon Educators Benefit Board or the Oregon Health and Science University.*]

(b) "Synchronization policy" means a procedure for aligning the refill dates of a patient's prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently.

(2) A health plan that includes prescription drug coverage shall implement a synchronization policy for the dispensing of prescription drugs to the plan's enrollees.

(3) A health plan shall reimburse the cost of prescription drugs dispensed in accordance with the plan's synchronization policy.

(4) If a drug is dispensed in less than a 30-day supply for the purpose of synchronizing a patient's prescription drug refills, a health plan shall:

(a) Prorate the copayment; or

(b) Adjust the copayment using a method approved by the Department of Consumer and Business Services.

(5) A health plan shall fully reimburse the dispensing fee for partially filled or refilled prescription drugs.

(6) This section does not apply to prescription drugs that:

(a) Are in unit-of-use packaging for which synchronization is not possible;

(b) Are controlled substances; or

(c) Have been identified by the United States Drug Enforcement Administration as having a high risk of diversion.

(7) The coverage required by this section may be limited by formulary restrictions applied to a prescription drug by a health plan.

(8)(a) This section does not apply to a prepaid group practice health plan with at least 200,000 enrollees in this state.

(b) As used in this subsection, "prepaid group practice health plan" means a health care service contractor that provides physician services to its enrollees through an integrated health care delivery system using, primarily, a single group of physicians contracted on a prepaid, capitated basis.

SECTION 54. ORS 743B.810 is amended to read:

743B.810. (1) A health benefit plan may not exclude, and shall expedite preauthorizations required for, work-related injuries or occupational diseases if:

(a) The injured worker is covered by workers' compensation insurance and the health benefit plan; and

(b) The injured worker has submitted a workers' compensation claim for the work-related injury or occupational disease that has not been accepted or denied by the workers' compensation carrier.

(2) A health benefit plan subject to this section shall guarantee payment for preauthorized medical services to the provider of those medical services according to the terms, conditions and benefits of the plan if the claim is found not to be a compensable workers' compensation claim.

(3) As used in this section, "health benefit plan" has the meaning given that term in ORS 743B.005 [*and also means self-insured benefit plans and health benefit plans provided by the Oregon Educators Benefit Board and the Public Employees' Benefit Board*].

(4) The provisions of ORS 743A.001 do not apply to this section.

SECTION 55. ORS 757.822 is amended to read:

757.822. (1) Except as provided in subsection (2) of this section, the provisions of ORS chapters 35, other than ORS 35.550 to 35.575, 180, 190, 192 and 244 and ORS 30.260 to 30.460, 200.005 to 200.025, 200.045 to 200.090, 221.450, 236.605 to 236.640, 243.650 to 243.782, other than 243.696, 297.040, 307.090 and 307.112 apply to Oregon Community Power under the same terms as they apply to any other subdivision of state government.

(2) Except as otherwise provided by law, the provisions of ORS chapters 182, 183, 238, 238A, 240, 270, 273, 276, 279A, 279B, 279C, 283, 286A, 291, 292, 293, 294, 295 and 297 and ORS 35.550 to 35.575, 183.710 to 183.725, 183.745, 183.750, 184.305 to 184.345, 190.430, 190.480, 190.490, 192.105, 200.035, 243.105 to 243.585, 243.696, 278.011 to 278.120, 278.315 to 278.415, 279.835 to 279.855, 282.010 to 282.150, 283.085 to 283.092, 287A.140, 287A.150, 287A.472 and 656.017 (2) **and section 3 of this 2017 Act** do not apply to Oregon Community Power.

(3) Oregon Community Power is not a participating public employer in the Public Employees Retirement System.

(4) Any funds held by or under the control of Oregon Community Power are not public funds, as defined in ORS 295.001.

SECTION 56. Section 4, chapter 771, Oregon Laws 2013, as amended by section 11, chapter 674, Oregon Laws 2015, is amended to read:

Sec. 4. (1) An individual actively practicing applied behavior analysis as defined in [*section 1 of this 2015 Act*] **ORS 676.802** on August 14, 2013, may continue to claim reimbursement from a health benefit plan, the [*Public Employees' Benefit Board or the Oregon Educators Benefit Board*]

Oregon Health Authority or a coordinated care organization, as defined in ORS 414.025, for services provided without a license before July 1, 2018.

(2) An individual may claim reimbursement under subsection (1) of this section only if the individual submits a satisfactory declaration and other required documentation to the Health Licensing Office not later than April 30, 2016.

SECTION 57. Section 1, chapter 389, Oregon Laws 2015, is amended to read:

Sec. 1. (1) The Oregon Health Policy Board, in consultation with the [*Public Employees' Benefit Board, the Oregon Educators Benefit Board, the*] Oregon Health Authority and the Department of Consumer and Business Services shall develop a statewide strategic plan for the collection and use of health care data. The plan must:

(a) Include clear objectives for how health care data will be used, and what types of data are needed, in state health care programs to support health system transformation efforts and promote value;

(b) Allow for alignment of performance metrics across state health care programs;

(c) Ensure that the state's efforts in the collection and use of health care data encourage integrated and coordinated care, promote improved quality, health outcomes and patient satisfaction and help reduce costs;

(d) Include strategies to ensure that the state's collection, use and measurement of health care data advance payment reform and allow for alternative payment methodologies;

(e) To the extent practicable, allow for alternative reporting and measurement mechanisms that are not claims-based or that are for payers and providers who are moving away from fee-for-service based reimbursement;

(f) Identify appropriate and inappropriate uses of health care data, including safeguards to ensure privacy and ensure that data is not used for marketing or other inappropriate purposes; and

(g) Outline a five-year vision including implementation timelines in sufficient detail that health care stakeholders can plan for expected new data reporting requirements and uses.

(2) The Oregon Health Policy Board shall submit the plan developed under subsection (1) of this section to the interim committees of the Legislative Assembly related to health care no later than September 1, 2016.

(3) The performance measures developed by the Health Plan Quality Metrics Committee established under ORS 413.017 (4) must be aligned with the statewide strategic plan adopted under this section.

SECTION 58. ORS 243.275 is amended to read:

243.275. (1) [*In addition to contracting for health and dental benefit plans,*] The Public Employees' Benefit Board may contract with carriers to provide at the expense of participating eligible employees and with or without state or local government participation for coverage, including but not limited to, insurance or other benefit based on life, supplemental medical, supplemental dental, optical, accidental death or disability insurance plans.

(2) The monthly contribution of each eligible employee for other benefit plan or plans coverage, as described in subsection (1) of this section, shall be the total cost per month of the benefit coverage afforded the employee under the plan or plans, for which the employee exercises an option, including the cost of enrollment and administrative expenses.

(3) For any benefit plan or plans described in subsection (1) of this section in which the state or a local government participates, the monthly contribution of each eligible employee for the benefit plan, for which the employee exercises an option and there is state or local government partic-

ipation, shall be reduced by an amount equal to the portion contributed by the state or the local government, including the cost of enrollment and administrative expenses.

(4) The board may withdraw approval of any such additional benefit plan coverage in the [*same*] manner [*as it withdraws approval of health benefit plans as described and*] authorized by ORS 243.145.

(5) If any state agency or local government contracts for any of the benefits described in subsection (1) of this section on behalf of any eligible employees, the administrative expenses of the contract shall be paid by assessment of the participating employees. The contracts are subject to approval of the board before they become operative. The board may withdraw approval for any such benefit in the same manner as it withdraws approval under ORS 243.145.

SECTION 59. Section 3, chapter 575, Oregon Laws 2015, as amended by section 7, chapter 26, Oregon Laws 2016, is amended to read:

Sec. 3. No later than February 1 of each year, the Oregon Health Authority and the Department of Consumer and Business Services shall report to the Legislative Assembly, in the manner provided in ORS 192.245:

(1) The percentage of the medical expenses of carriers[,] **and** coordinated care organizations[*, the Public Employees' Benefit Board and the Oregon Educators Benefit Board*] that is allocated to primary care; and

(2) How carriers[,] **and** coordinated care organizations[*, the Public Employees' Benefit Board and the Oregon Educators Benefit Board*] pay for primary care.

ABOLISHMENT OF OREGON EDUCATORS BENEFIT BOARD

SECTION 60. (1) The Oregon Educators Benefit Board is abolished. On the operative date of this section, the tenure of office of the members of the Oregon Educators Benefit Board ceases.

(2) All the duties, functions and powers of the Oregon Educators Benefit Board are imposed upon, transferred to and vested in the Public Employees' Benefit Board.

(3) The Oregon Educators Benefit Board shall:

(a) Deliver to the Public Employees' Benefit Board all records and property within the jurisdiction of the Oregon Educators Benefit Board that relate to the duties, functions and powers transferred by subsection (2) of this section; and

(b) Transfer to the Public Employees' Benefit Board those employees engaged primarily in the exercise of the duties, functions and powers transferred by subsection (1) of this section.

(4) The executive director of the Public Employees' Benefit Board shall take possession of the records and property, and shall take charge of the employees and employ them in the exercise of the duties, functions and powers transferred by subsection (2) of this section, without reduction of compensation but subject to change or termination of employment or compensation as provided by law.

(5) The Governor shall resolve any dispute between the Oregon Educators Benefit Board and the Public Employees' Benefit Board relating to transfers of records, property and employees under this section, and the Governor's decision is final.

(6) The Oregon Educators Benefit Account and the Oregon Educators Revolving Fund are abolished. The unexpended balances of amounts remaining in the Oregon Educators Benefit

Account and the Oregon Educators Revolving Fund on the operative date of this section are transferred to the Public Employees Benefit Account and are available for expenditure by the Public Employees' Benefit Board for the biennium beginning July 1, 2017, for the purpose of administering and enforcing the duties, functions and powers transferred by subsection (2) of this section.

(7) The expenditure classifications, if any, established by Acts authorizing or limiting expenditures by the Oregon Educators Benefit Board remain applicable to expenditures by the Public Employees' Benefit Board under this section.

(8) The transfer of duties, functions and powers to the Public Employees' Benefit Board by subsection (2) of this section does not affect any action, proceeding or prosecution involving or with respect to such duties, functions and powers begun before and pending at the time of the transfer, except that the Public Employees' Benefit Board is substituted for the Oregon Educators Benefit Board in the action, proceeding or prosecution.

(9) Nothing in sections 2 to 4 and 60 to 64 of this 2017 Act or the amendments to ORS 192.556, 196.165, 238.410, 238.415, 238.538, 240.309, 243.061, 243.105, 243.107, 243.125, 243.129, 243.140, 243.145, 243.163, 243.185, 243.215, 243.221, 243.252, 243.256, 243.275, 243.285, 243.302, 243.879, 279A.025, 292.051, 346.565, 350.355, 352.129, 352.237, 413.011, 413.017, 413.260, 414.312, 414.314, 414.625, 414.661, 414.764, 421.352, 442.396, 471.752, 565.456, 565.470, 653.300, 656.247, 741.300, 741.310, 743A.058, 743B.601, 743B.810 and 757.822 and section 4, chapter 771, Oregon Laws 2013, section 1, chapter 389, Oregon Laws 2015, and section 3, chapter 575, Oregon Laws 2015, by sections 5 to 59 of this 2017 Act or the repeal of ORS 243.135, 243.142, 243.160, 243.205, 243.256, 243.303, 243.860, 243.862, 243.864, 243.866, 243.867, 243.868, 243.870, 243.872, 243.874, 243.876, 243.878, 243.879, 243.880, 243.882, 243.884 and 243.886 by sections 69 and 70 of this 2017 Act relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions and powers transferred by subsection (2) of this section. The Public Employees' Benefit Board may undertake the collection or enforcement of any such liability, duty or obligation.

(10) The rights and obligations of the Oregon Educators Benefit Board legally incurred under contracts, leases and business transactions executed, entered into or begun before the operative date of this section are transferred to the Public Employees' Benefit Board. For the purpose of succession to these rights and obligations, the Public Employees' Benefit Board is a continuation of the Oregon Educators Benefit Board and not a new authority.

SECTION 61. Notwithstanding the transfer of duties, functions and powers by section 60 of this 2017 Act, the rules of the Oregon Educators Benefit Board in effect on the operative date of section 60 of this 2017 Act continue in effect until superseded or repealed by rules of the Public Employees' Benefit Board. References in rules of the Oregon Educators Benefit Board to the Oregon Educators Benefit Board or an officer or employee of the Oregon Educators Benefit Board are considered to be references to the Public Employees' Benefit Board or an officer or employee of the Public Employees' Benefit Board.

SECTION 62. Whenever, in any statutory law or resolution of the Legislative Assembly or in any rule, document, record or proceeding authorized by the Legislative Assembly, reference is made to the Oregon Educators Benefit Board or an officer or employee of the Oregon Educators Benefit Board, the reference is considered to be a reference to the Public Employees' Benefit Board or an officer or employee of the Public Employees' Benefit Board.

SECTION 63. For the purpose of harmonizing and clarifying statutory law, the Legislative

Counsel may substitute for words designating the:

(1) "Oregon Educators Benefit Board" or its officers, wherever they occur in statutory law, words designating the "Public Employees' Benefit Board" or its officers.

(2) "Oregon Educators Benefit Account" and the "Oregon Educators Revolving Fund," wherever they occur in statutory law, words designating the "Public Employees' Benefit Account."

SECTION 64. The executive director of the Public Employees' Benefit Board may take any action before the operative date of this section that is necessary to enable the executive director to exercise, on and after the operative date of section 60 of this 2017 Act, the duties, functions and powers transferred under section 60 of this 2017 Act.

OPERATIVE DATES/REPEALS

SECTION 65. The amendments to ORS 243.256 and 243.879 by sections 31 and 32 of this 2017 Act apply to payments to hospitals for services provided by the hospitals on or after the effective date of this 2017 Act and before January 2, 2019.

SECTION 66. Sections 2, 3 and 60 to 64 of this 2017 Act and the amendments to ORS 192.556, 196.165, 238.410, 238.415, 238.538, 240.309, 243.061, 243.105, 243.107, 243.125, 243.129, 243.140, 243.145, 243.163, 243.185, 243.215, 243.221, 243.252, 243.275, 243.285, 243.302, 279A.025, 292.051, 346.565, 350.355, 352.129, 413.011, 413.017, 413.260, 414.312, 414.314, 414.625, 414.661, 414.764, 442.396, 471.752, 565.470, 653.300, 656.247, 741.300, 741.310, 743A.058, 743B.601, 743B.810 and 757.822 and section 4, chapter 771, Oregon Laws 2013, section 1, chapter 389, Oregon Laws 2015, and section 3, chapter 575, Oregon Laws 2015, by sections 5 to 15, 17 to 30, 33 to 37, 39 to 43, 45, 46 and 48 to 59 of this 2017 Act become operative on January 2, 2019.

SECTION 67. The amendments to section 3 of this 2017 Act by section 4 of this 2017 Act and the amendments to ORS 279A.025, 352.237, 421.352 and 565.456 by sections 16, 38, 44 and 47 of this 2017 Act become operative on January 2, 2021.

SECTION 68. Section 1 of this 2017 Act is repealed on December 31, 2018.

SECTION 69. ORS 243.303 is repealed January 2, 2021.

SECTION 70. ORS 243.135, 243.142, 243.160, 243.205, 243.256, 243.860, 243.862, 243.864, 243.866, 243.867, 243.868, 243.870, 243.872, 243.874, 243.876, 243.878, 243.879, 243.880, 243.882, 243.884 and 243.886 are repealed on January 2, 2019.

CAPTIONS

SECTION 71. 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.

EMERGENCY CLAUSE

SECTION 72. This 2017 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2017 Act takes effect on its passage.
