

DRAFT

SUMMARY

Requires Public Employees' Benefit Board and Oregon Educators Benefit Board to offer at least one integrated health benefit plan meeting specified requirements in 2023. Requires all health benefit plans offered by boards to be integrated plans meeting specified requirements beginning in 2026. Prohibits boards from imposing caps on reimbursement paid to providers in integrated health benefit plans.

Expands membership of metrics and scoring subcommittee to include two representatives of public employees.

A BILL FOR AN ACT

Relating to health benefit plans for public employees; creating new provisions; amending ORS 243.105, 243.107, 243.125, 243.135, 243.160, 243.163, 243.215, 243.221, 243.256, 243.864, 243.866, 243.874, 243.879, 414.638, 442.394 and 442.396; and repealing ORS 243.256 and 243.879.

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

2023 TO 2025 PLAN YEAR PROVISIONS

(Public Employees' Benefit Board)

SECTION 1. Section 2 of this 2021 Act is added to and made a part of ORS 243.105 to 243.285.

SECTION 2. (1) As used in this section, "service cost payment scale" means the costs and fee schedules in effect on the effective date of this 2021 Act.

(2) An insurer or third party administrator that contracts with the Public Employees' Benefit Board to provide or administer a health

benefit plan must offer at least one health benefit plan that:

(a) Contracts with a provider group to deliver integrated physical, mental and oral health care to public employees within a defined geographic area using a patient-centered primary care home model.

(b) Delegates to a patient and the patient's provider the right to make all decisions regarding the patient's care with the goal of delivering care for the right reason at the right time and in the right place.

(c) Is paid a global budget on a per member per month basis, adjusted to reflect costs in the geographic area served by the plan and based on the service cost payment scale.

(3) The care provided under the plan is subject to the health outcome and quality measures selected by the metrics and scoring subcommittee of the Health Plan Quality Metrics Committee under ORS 414.638. The plan shall provide incentive payments to providers who provide care that meets or exceeds the health outcome and quality measures.

(4) The plan and the plan's provider group shall be responsible for all financial risk in operating within the global budget. If the plan operates at a cost below the global budget, the plan must share the savings with the plan's provider group in a manner prescribed by the Oregon Health Authority by rule.

(5) Global budgets may not increase year-to-year more than a percentage set by the Oregon Health Policy Board not to exceed 3.4 percent.

(6) The authority shall establish, by January 1, 2024, a five-star rating system for all plans offered to public employees and rate the plans based on patient satisfaction surveys and health outcome and quality measures. The ratings shall be posted to the Public Employees' Benefit Board's website and available to public employees when selecting a plan during open or special enrollment periods.

(7) In contracting with an insurer or a third party administrator to

offer a plan described in this section, the board shall ensure that:

(a) Public employees have the opportunity to select their provider groups;

(b) There will be no reduction in the scope or coverage of care from the previous plan year;

(c) Public employees who participate in the plan will have out-of-pocket costs or deductibles no greater than the employees' out-of-pocket costs in the previous plan year; and

(d) Any cost savings realized by the Public Employees' Benefit Board will be invested in improving employee benefits including salaries.

(8) Global budgets paid to insurers and third party administrators for plans described in this section shall be no less than the payments to the plans in the previous plan year.

(9) The board may not restrict or prescribe the reimbursement of providers participating in plans described in this section.

SECTION 3. Section 2 of this 2021 Act is amended to read:

Sec. 2. (1) As used in this section, "service cost payment scale" means the costs and fee schedules in effect [*on the effective date of this 2021 Act*] during the previous plan year.

(2) An insurer or third party administrator that contracts with the Public Employees' Benefit Board to provide or administer a health benefit plan must offer at least one health benefit plan that:

(a) Contracts with a provider group to deliver integrated physical, mental and oral health care to public employees within a defined geographic area using a patient-centered primary care home model.

(b) Delegates to a patient and the patient's provider the right to make all decisions regarding the patient's care with the goal of delivering care for the right reason at the right time and in the right place.

(c) Is paid a global budget on a per member per month basis, adjusted to reflect costs in the geographic area served by the plan and based on the

1 service cost payment scale.

2 (3) The care provided under the plan is subject to the health outcome and
3 quality measures selected by the metrics and scoring subcommittee of the
4 Health Plan Quality Metrics Committee under ORS 414.638. The plan shall
5 provide incentive payments to providers who provide care that meets or ex-
6 ceeds the health outcome and quality measures.

7 (4) The plan and the plan's provider group shall be responsible for all fi-
8 nancial risk in operating within the global budget. If the plan operates at a
9 cost below the global budget, the plan must share the savings with the plan's
10 provider group in a manner prescribed by the Oregon Health Authority by
11 rule.

12 (5) Global budgets may not increase year-to-year more than a percentage
13 set by the Oregon Health Policy Board not to exceed 3.4 percent.

14 (6) The authority shall establish, by January 1, 2024, a five-star rating
15 system for all plans offered to public employees and rate the plans based on
16 patient satisfaction surveys and health outcome and quality measures. The
17 ratings shall be posted to the Public Employees' Benefit Board's website and
18 available to public employees when selecting a plan during open or special
19 enrollment periods.

20 (7) In contracting with an insurer or a third party administrator to offer
21 a plan described in this section, the board shall ensure that:

22 (a) Public employees have the opportunity to select their provider groups;

23 (b) There will be no reduction in the scope or coverage of care from the
24 previous plan year;

25 (c) Public employees who participate in the plan will have out-of-pocket
26 costs or deductibles no greater than the employees' out-of-pocket costs in the
27 previous plan year; and

28 (d) Any cost savings realized by the Public Employees' Benefit Board will
29 be invested in improving employee benefits including salaries.

30 (8) Global budgets paid to insurers and third party administrators for
31 plans described in this section shall be no less than the payments to the

plans in the previous plan year.

(9) The board may not restrict or prescribe the reimbursement of providers participating in plans described in this section.

SECTION 4. ORS 243.256 is amended to read:

243.256. (1) A carrier that contracts with the Public Employees' Benefit Board to provide to eligible employees and their dependents a benefit plan that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(2) A self-insurance program administered by a third party administrator that is offered by the board to eligible employees and their dependents and that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section may not charge to or collect from the patient or a person who is financially responsible for the patient an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other than cost sharing amounts authorized by the terms of the health benefit plan.

(4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis, the payment method used must take into account the

limits specified in subsections (1) and (2) of this section. Such payment methods include, but are not limited to:

- (a) Value-based payments;
- (b) Capitation payments; and
- (c) Bundled payments.

(5) This section does not apply to reimbursements paid by a carrier or third party administrator to:

- (a) A type A or type B hospital as described in ORS 442.470;
- (b) A rural critical access hospital as defined in ORS 315.613;
- (c) A hospital:

(A) Located in a county with a population of less than 70,000 on August 15, 2017;

(B) Classified as a sole community hospital by the Centers for Medicare and Medicaid Services; and

(C) With Medicare payments composing at least 40 percent of the hospital's total annual patient revenue; *[or]*

(d) A hospital located outside of this state; **or**

(e) A hospital for services provided to public employees enrolled in a health benefit plan described in section 2 of this 2021 Act.

(6) This section does not require a health benefit plan offered by the board to reimburse claims using a fee-for-service payment method.

(Oregon Educators Benefit Board)

SECTION 5. Section 6 of this 2021 Act is added to and made a part of ORS 243.860 to 243.886.

SECTION 6. (1) As used in this section, “service cost payment scale” means the costs and fee schedules in effect on the effective date of this 2021 Act.

(2) An insurer or third party administrator that contracts with the Oregon Educators Benefit Board to provide or administer a health

1 **benefit plan must offer at least one health benefit plan that:**

2 **(a) Contracts with a provider group to deliver integrated physical,**
3 **mental and oral health care to public employees within a defined ge-**
4 **ographic area using a patient-centered primary care home model.**

5 **(b) Delegates to the patient and the patient's provider the right to**
6 **make all decisions regarding the patient's care with the goal of deliv-**
7 **ering care for the right reason at the right time and in the right place.**

8 **(c) Is paid a global budget on a per member per month basis, ad-**
9 **justed to reflect costs in the geographic area served by the plan and**
10 **based on the service cost payment scale.**

11 **(3) The care provided under the plan is subject to the health out-**
12 **come and quality measures selected by the metrics and scoring sub-**
13 **committee of the Health Plan Quality Metrics Committee under ORS**
14 **414.638. The plan shall provide incentive payments to providers who**
15 **provide care that meets or exceeds the health outcome and quality**
16 **measures.**

17 **(4) The plan and the plan's provider group shall be responsible for**
18 **all financial risk in operating within the global budget. If the plan**
19 **operates at a cost below the global budget, the plan must share the**
20 **savings with the plan's provider group in a manner prescribed by the**
21 **Oregon Health Authority by rule.**

22 **(5) Global budgets may not increase year-to-year more than a per-**
23 **centage set by the Oregon Health Policy Board not to exceed 3.4 per-**
24 **cent.**

25 **(6) The authority shall establish, by January 1, 2024, a five-star**
26 **rating system for all plans offered to public employees and rate the**
27 **plans based on patient satisfaction surveys and health outcome and**
28 **quality measures. The ratings shall be posted to the Oregon Educators**
29 **Benefit Board's website and available to public employees when se-**
30 **lecting a plan during open or special enrollment periods.**

31 **(7) In contracting with an insurer or a third party administrator to**

offer a plan described in this section, the board shall ensure that:

(a) Public employees have the opportunity to select their provider groups;

(b) There will be no reduction in the scope or coverage of care from the previous plan year;

(c) Public employees who participate in the plan will have out-of-pocket costs or deductibles no greater than the employees' out-of-pocket costs in the previous plan year; and

(d) Any cost savings realized by the Oregon Educators Benefit Board will be invested in improving employee benefits including salaries.

(8) Global budgets paid to insurers and third party administrators for plans described in this section shall be no less than the payments to the plans in the previous plan year.

(9) The board may not restrict or prescribe the reimbursement of providers participating in plans described in this section.

SECTION 7. Section 6 of this 2021 Act is amended to read:

Sec. 6. (1) As used in this section, "service cost payment scale" means the costs and fee schedules in effect [*on the effective date of this 2021 Act*] during the previous plan year.

(2) An insurer or third party administrator that contracts with the Oregon Educators Benefit Board to provide or administer a health benefit plan must offer at least one health benefit plan that:

(a) Contracts with a provider group to deliver integrated physical, mental and oral health care to public employees within a defined geographic area using a patient-centered primary care home model.

(b) Delegates to the patient and the patient's provider the right to make all decisions regarding the patient's care with the goal of delivering care for the right reason at the right time and in the right place.

(c) Is paid a global budget on a per member per month basis, adjusted to reflect costs in the geographic area served by the plan and based on the

1 service cost payment scale.

2 (3) The care provided under the plan is subject to the health outcome and
3 quality measures selected by the metrics and scoring subcommittee of the
4 Health Plan Quality Metrics Committee under ORS 414.638. The plan shall
5 provide incentive payments to providers who provide care that meets or ex-
6 ceeds the health outcome and quality measures.

7 (4) The plan and the plan's provider group shall be responsible for all fi-
8 nancial risk in operating within the global budget. If the plan operates at a
9 cost below the global budget, the plan must share the savings with the plan's
10 provider group in a manner prescribed by the Oregon Health Authority by
11 rule.

12 (5) Global budgets may not increase year-to-year more than a percentage
13 set by the Oregon Health Policy Board not to exceed 3.4 percent.

14 (6) The authority shall establish, by January 1, 2024, a five-star rating
15 system for all plans offered to public employees and rate the plans based on
16 patient satisfaction surveys and health outcome and quality measures. The
17 ratings shall be posted to the Oregon Educators Benefit Board's website and
18 available to public employees when selecting a plan during open or special
19 enrollment periods.

20 (7) In contracting with an insurer or a third party administrator to offer
21 a plan described in this section, the board shall ensure that:

22 (a) Public employees have the opportunity to select their provider groups;

23 (b) There will be no reduction in the scope or coverage of care from the
24 previous plan year;

25 (c) Public employees who participate in the plan will have out-of-pocket
26 costs or deductibles no greater than the employees' out-of-pocket costs in the
27 previous plan year; and

28 (d) Any cost savings realized by the Oregon Educators Benefit Board will
29 be invested in improving employee benefits including salaries.

30 (8) Global budgets paid to insurers and third party administrators for
31 plans described in this section shall be no less than the payments to the

plans in the previous plan year.

(9) The board may not restrict or prescribe the reimbursement of providers participating in plans described in this section.

SECTION 8. ORS 243.879 is amended to read:

243.879. (1) A carrier that contracts with the Oregon Educators Benefit Board to provide to eligible employees and their dependents a benefit plan that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(2) A self-insurance program administered by a third party administrator that is offered by the board to eligible employees and their dependents and that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section may not charge to or collect from the patient or a person who is financially responsible for the patient an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other than cost sharing amounts authorized by the terms of the health benefit plan.

(4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis, the payment method used must take into account the

limits specified in subsections (1) and (2) of this section. Such payment methods include, but are not limited to:

- (a) Value-based payments;
- (b) Capitation payments; and
- (c) Bundled payments.

(5) This section does not apply to reimbursements paid by a carrier or third party administrator to:

- (a) A type A or type B hospital as described in ORS 442.470;
- (b) A rural critical access hospital as defined in ORS 315.613;
- (c) A hospital:

(A) Located in a county with a population of less than 70,000 on August 15, 2017;

(B) Classified as a sole community hospital by the Centers for Medicare and Medicaid Services; and

(C) With Medicare payments composing at least 40 percent of the hospital's total annual patient revenue; *[or]*

(d) A hospital located outside of this state; **or**

(e) A hospital for services provided to public employees enrolled in a health benefit plan described in section 6 of this 2021 Act.

(6) This section does not require a health benefit plan offered by the board to reimburse claims using a fee-for-service payment method.

PROVISIONS FOR PLAN YEARS BEGINNING IN 2026

(Public Employees' Benefit Board)

SECTION 9. Section 2 of this 2021 Act, as amended by section 3 of this 2021 Act, is amended to read:

Sec. 2. (1) As used in this section, "service cost payment scale" means the costs and fee schedules in effect during the previous plan year.

(2) An insurer or third party administrator that contracts with the Public Employees' Benefit Board to provide or administer a health benefit plan must

offer [*at least one*] health benefit [*plan*] **plans** that:

(a) [*Contracts*] **Contract** with a provider group to deliver integrated physical, mental and oral health care to public employees within a defined geographic area using a patient-centered primary care home model.

(b) [*Delegates*] **Delegate** to the patient and the patient's provider the right to make all decisions regarding the patient's care with the goal of delivering care for the right reason at the right time and in the right place.

(c) [*Is*] **Are** paid a global budget on a per member per month basis, adjusted to reflect costs in the geographic area served by the plan and based on the service cost payment scale.

(3) The care provided under [*the*] **a** plan is subject to the health outcome and quality measures selected by the metrics and scoring subcommittee of the Health Plan Quality Metrics Committee under ORS 414.638. [*The*] **A** plan shall provide incentive payments to providers who provide care that meets or exceeds the health outcome and quality measures.

(4) [*The*] **A** plan and the plan's provider group shall be responsible for all financial risk in operating within the global budget. If the plan operates at a cost below the global budget, the plan must share the savings with the plan's provider group in a manner prescribed by the Oregon Health Authority by rule.

(5) Global budgets may not increase year-to-year more than a percentage set by the Oregon Health Policy Board not to exceed 3.4 percent.

(6) The authority shall establish[, *by January 1, 2024,*] a five-star rating system for all plans offered to public employees and rate the plans based on patient satisfaction surveys and health outcome and quality measures. The ratings shall be posted to the Public Employees' Benefit Board's website and available to public employees when selecting a plan during open or special enrollment periods.

(7) In contracting with an insurer or a third party administrator to offer a plan [*described in*] **under** in this section, the board shall ensure that:

(a) Public employees have the opportunity to select their provider groups;

(b) There will be no reduction in the scope or coverage of care from the previous plan year;

(c) Public employees who participate in the plan will have out-of-pocket costs or deductibles no greater than the employees' out-of-pocket costs in the previous plan year; and

(d) Any cost savings realized by the Public Employees' Benefit Board will be invested in improving employee benefits including salaries.

(8) Global budgets paid to insurers and third party administrators for plans described in this section shall be no less than the payments to the plans in the previous plan year.

(9) The board may not restrict or prescribe the reimbursement of providers participating in plans described in this section.

SECTION 10. ORS 243.135 is amended to read:

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

[(a) Employee choice among high quality plans;]

[(b) A competitive marketplace;]

[(c) Plan performance and information;]

[(d) Employer flexibility in plan design and contracting;]

[(e) Quality customer service;]

[(f) Creativity and innovation;]

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

[(h) The improvement of employee health; and]

[(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan] **described in section 2 of this 2021 Act.**

(2) The board may approve more than one carrier for each type of plan contracted for and offered but the number of carriers shall be held to a

number consistent with adequate service to eligible employees and their family members.

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

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

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

(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and their family members under rules adopted by the board. Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

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

[(8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by the board that are designed to limit the growth in

per-member expenditures for health services to no more than 3.4 percent per year. The assessment paid in accordance with section 3, chapter 538, Oregon Laws 2017, shall be excluded in determining the 3.4 percent annual increase in per-member expenditures for health services.]

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

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

[(10) By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care.]

[(11) No later than February 1 of each year, the board shall report to the Legislative Assembly on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care.]

SECTION 11. ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, section 12, chapter 2, Oregon Laws 2019, and section 2, chapter 484, Oregon Laws 2019, is amended to read:

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

[(a) Employee choice among high quality plans;]

[(b) A competitive marketplace;]

[(c) Plan performance and information;]

1 [(d) *Employer flexibility in plan design and contracting;*]

2 [(e) *Quality customer service;*]

3 [(f) *Creativity and innovation;*]

4 [(g) *Plan benefits as part of total employee compensation;*]

5 [(h) *The improvement of employee health; and*]

6 [(i) *Health outcome and quality measures, described in ORS 413.017 (4),*
7 *that are reported by the plan*] **described in section 2 of this 2021 Act.**

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

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

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

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

27 (6) Transfer of enrollment from one plan to another shall be open to all
28 eligible employees and their family members under rules adopted by the
29 board. Because of the special problems that may arise in individual instances
30 under comprehensive group practice plan coverage involving acceptable
31 provider-patient relations between a particular panel of providers and par-

1 ticular eligible employees and their family members, the board shall provide
2 a procedure under which any eligible employee may apply at any time to
3 substitute a health service benefit plan for participation in a comprehensive
4 group practice benefit plan.

5 (7) The board shall evaluate a benefit plan that serves a limited ge-
6 ographic region of this state *[according to the criteria described in subsection*
7 *(1) of this section]*.

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

14 *[(b) The board shall adopt policies and practices designed to limit the an-*
15 *nual increase in premium amounts paid for contracted health benefit plans to*
16 *3.4 percent.]*

17 [(9)] (8) As frequently as is recommended as a commercial best practice
18 by consultants engaged by the board, the board shall conduct an audit of the
19 health benefit plan enrollees' continued eligibility for coverage as spouses
20 or dependents or any other basis that would affect the cost of the premium
21 for the plan.

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

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

(Oregon Educators Benefit Board)

SECTION 12. Section 6 of this 2021 Act, as amended by section 7 of this 2021 Act, is amended to read:

Sec. 6. (1) As used in this section, “service cost payment scale” means the costs and fee schedules in effect during the previous plan year.

(2) An insurer or third party administrator that contracts with the Oregon Educators Benefit Board to provide or administer a health benefit plan must offer *[at least one]* health benefit *[plan]* **plans** that:

(a) *[Contracts]* **Contract** with a provider group to deliver integrated physical, mental and oral health care to public employees within a defined geographic area using a patient-centered primary care home model.

(b) *[Delegates]* **Delegate** to the patient and the patient’s provider the right to make all decisions regarding the patient’s care with the goal of delivering care for the right reason at the right time and in the right place.

(c) *[Is]* **Are** paid a global budget on a per member per month basis, adjusted to reflect costs in the geographic area served by the plan and based on the service cost payment scale.

(3) The care provided under *[the]* **a** plan is subject to the health outcome and quality measures selected by the metrics and scoring subcommittee of the Health Plan Quality Metrics Committee under ORS 414.638. *[The]* **A** plan shall provide incentive payments to providers who provide care that meets or exceeds the health outcome and quality measures.

(4) *[The]* **A** plan and the plan’s provider group shall be responsible for all financial risk in operating within the global budget. If the plan operates at a cost below the global budget, the plan must share the savings with the plan’s provider group in a manner prescribed by the Oregon Health Authority by rule.

(5) Global budgets may not increase year-to-year more than a percentage set by the Oregon Health Policy Board not to exceed 3.4 percent.

(6) The authority shall establish~~ed~~, *by January 1, 2024,* a five-star rating

system for all plans offered to public employees and rate the plans based on patient satisfaction surveys and health outcome and quality measures. The ratings shall be posted to the Oregon Educators Benefit Board's website and available to public employees when selecting a plan during open or special enrollment periods.

(7) In contracting with an insurer or a third party administrator to offer a plan *[described in]* **under** in this section, the board shall ensure that:

(a) Public employees have the opportunity to select their provider groups;

(b) There will be no reduction in the scope or coverage of care from the previous plan year;

(c) Public employees who participate in the plan will have out-of-pocket costs or deductibles no greater than the employees' out-of-pocket costs in the previous plan year; and

(d) Any cost savings realized by the Oregon Educators Benefit Board will be invested in improving employee benefits including salaries.

(8) Global budgets paid to insurers and third party administrators for plans described in this section shall be no less than the payments to the plans in the previous plan year.

(9) The board may not restrict or prescribe the reimbursement of providers participating in plans described in this section.

SECTION 13. ORS 243.866 is amended to read:

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

[(a) Employee choice among high-quality plans;]

[(b) Encouragement of a competitive marketplace;]

[(c) Plan performance and information;]

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

[(e) Quality customer service;]

1 [(f) *Creativity and innovation;*]

2 [(g) *Plan benefits as part of total employee compensation;*]

3 [(h) *Improvement of employee health; and*]

4 [(i) *Health outcome and quality measures, described in ORS 413.017 (4),*
5 *that are reported by the plan*] **described in section 6 of this 2021 Act.**

6 (2) The board may approve more than one carrier for each type of benefit
7 plan offered, but the board shall limit the number of carriers to a number
8 consistent with adequate service to eligible employees and family members.
9 The board shall impose a surcharge in an amount determined by the board
10 on an eligible employee who arranges coverage for the employee's spouse or
11 dependent under this subsection if the spouse or dependent has access to
12 medical coverage as an employee in another health benefit plan offered by
13 the board or the Public Employees' Benefit Board.

14 (3) When appropriate, the board shall provide options under which an el-
15 igible employee may arrange coverage for family members under a benefit
16 plan.

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

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

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

for participation in a comprehensive group practice benefit plan.

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

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

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

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

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

[(11) By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care.]

[(12) No later than February 1 of each year, the board shall report to the Legislative Assembly on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures on payments for primary care.]

SECTION 14. ORS 243.866, as amended by section 17, chapter 489, Oregon Laws 2017, and section 4, chapter 484, Oregon Laws 2019, is amended to read:

243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans *[best designed to meet the needs and provide for the welfare of eligible*

employees, the districts and local governments. In considering whether to enter into a contract for a benefit plan, the board shall place emphasis on:]

[(a) Employee choice among high-quality plans;]

[(b) Encouragement of a competitive marketplace;]

[(c) Plan performance and information;]

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

[(e) Quality customer service;]

[(f) Creativity and innovation;]

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

[(h) Improvement of employee health; and]

*[(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan] **described in section 6 of this 2021 Act.***

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

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

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

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

tional premium.

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

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

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

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

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

~~[(10)]~~ (9) As frequently as is recommended as a commercial best practice by consultants engaged by the board, the board shall conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.

[(11) If the board spends less than 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care, the board shall implement a plan for increasing the percentage of total medical

expenditures spent on payments for primary care by at least one percent each year.]

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

(Conforming Amendments)

SECTION 15. 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, disability and other health care recognized by state law, 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)(a) "Eligible employee" means an officer or employee of a state agency or local government who elects to participate in one of the group benefit plans described in [ORS 243.135] **section 2 of this 2021 Act**. The term in-

cludes, 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) “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) “Local government” means any city, county or special district in this state or any intergovernmental entity created under ORS chapter 190.

(7) “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) “Premium” means the monthly or other periodic charge for a benefit plan.

(9) “Primary care” means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

(10) “State agency” means every state officer, board, commission, department or other activity of state government.

(11) “Total medical expenditures” means payments to reimburse the cost of physical and mental health care provided to eligible employees or their family members, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.

SECTION 16. 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] **section 2 of this 2021 Act** 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), 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), the person is employed on a less than half-time basis in an unclassified instructional or research support capacity and elects to participate.

SECTION 17. 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 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)(a)] (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)] **section 2 of this 2021 Act.**

[(b) *Premium rates established by the board for a self-insured health benefit plan and premium rates negotiated by the board with a carrier that offers a health benefit plan to eligible employees must take into account any reduction in the cost of hospital services and supplies anticipated to result from the application of ORS 243.256.*]

(5) The executive director of the board shall report to the Director of the Oregon Health Authority.

(6) 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. If the board contracts for actuarial or technical support to manage the functions of the board, the board shall, no less than every three years, solicit invitations to bid and the proposals must include all of the following:

(a) An explanation of how the bidder has assisted other clients in creating incentives to improve the quality of care provided to enrollees;

(b) An explanation of how the bidder will support the board's efforts to maximize provider efficiencies and achieve more organized systems of care; and

(c) A description of the bidder's experience in assisting other clients in structuring contracts that use risk-based networks of providers and alternative provider reimbursement methodologies.

SECTION 18. ORS 243.160 is amended to read:

243.160. A retired state or local government officer or employee is not required to participate in one of the group benefit plans described in [ORS 243.135] **section 2 of this 2021 Act** in order to obtain dental benefit plan coverage. The Public Employees' Benefit Board shall establish by rule standards of eligibility for retired officers or employees to participate in a dental benefit plan.

SECTION 19. 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] **section 2 of this 2021 Act** after the member ceases to be a member of the Legislative Assembly if the member applies to the Public Employees' Benefit Board within 60 days after the member ceases to be a member of the Legislative Assembly.

SECTION 20. ORS 243.215 is amended to read:

243.215. Any eligible employee unable to participate in one or more of the

plans described in [ORS 243.135 (1)] **section 2 of this 2021 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.

SECTION 21. 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 **and section 2 of this 2021 Act.**

(b) Other insurance benefits as provided in ORS 243.275.

(c) Dependent care assistance as provided in ORS 243.550.

(d) Expense reimbursement as provided in ORS 243.560.

(e) 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.

SECTION 22. ORS 243.864 is amended to read:

243.864. (1) The Oregon Educators Benefit Board:

(a) Shall adopt rules for the conduct of its business [*and for carrying out ORS 243.879*]; and

(b) May adopt rules not inconsistent with ORS 243.860 to 243.886 to determine the terms and conditions of eligible employee participation in and

coverage under benefit plans.

(2) The board shall study all matters connected with the provision of adequate benefit plan coverage for eligible employees on the best basis possible with regard to the welfare of the employees and affordability for the districts and local governments. The board shall design benefits, prepare specifications, analyze carrier responses to advertisements for bids and award contracts. Contracts shall be signed by the chairperson on behalf of the board.

(3) In carrying out its duties under subsections (1) and (2) of this section, the goal of the board is to provide high-quality health, dental and other benefit plans for eligible employees at a cost affordable to the districts and local governments, the employees and the taxpayers of Oregon.

(4)(a) The board shall prepare specifications, invite bids and take actions necessary to award contracts for health and dental benefit plan coverage of eligible employees in accordance with the criteria set forth in [ORS 243.866 (1)] **section 6 of this 2021 Act**.

[(b) Premium rates established by the board for a self-insured health benefit plan and premium rates negotiated by the board with a carrier that offers a health benefit plan to eligible employees must take into account any reduction in the cost of hospital services and supplies anticipated to result from the application of ORS 243.879.]

[(c)] **(b)** The Public Contracting Code does not apply to contracts for benefit plans provided under ORS 243.860 to 243.886. The board may not exclude from competition to contract for a benefit plan an Oregon carrier solely because the carrier does not serve all counties in Oregon.

(5) The board may retain consultants, brokers or other advisory personnel when necessary and shall employ such personnel as are required to perform the functions of the board. If the board contracts for actuarial or technical support to manage the functions of the board, the board shall, no less than every three years, solicit invitations to bid and the proposals must include all of the following:

(a) An explanation of how the bidder has assisted other clients in creating

incentives to improve the quality of care provided to enrollees;

(b) An explanation of how the bidder will support the board's efforts to maximize provider efficiencies and achieve more organized systems of care; and

(c) A description of the bidder's experience in assisting other clients in structuring contracts that use risk-based networks of providers and alternative provider reimbursement methodologies.

SECTION 23. ORS 243.874 is amended to read:

243.874. (1) In addition to the powers and duties otherwise provided by law to provide benefit plans for eligible employees, the Oregon Educators Benefit Board may provide and administer 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 described in ORS [243.864 and] 243.866 **and section 6 of this 2021 Act.**

(b) Other insurance benefits as described in ORS 243.868.

(c) Any other benefit that may be excluded from an employee's gross income under the federal Internal Revenue Code.

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

(3) In developing flexible benefit plans, the board shall design the plans on the best basis possible with regard to the welfare of the employees and affordability for the districts and local governments.

(4) The board may pay some or all of the cost of administering flexible benefit plans from funds authorized to pay general administrative expenses incurred by the board.

(5) The board shall adopt rules as the board considers necessary for the establishment and administration of flexible benefit plans.

(6) The board may contract with private organizations for administration of flexible benefit plans in accordance with rules adopted under subsection

(5) of this section.

SECTION 24. ORS 442.394 is amended to read:

442.394. (1) A hospital or ambulatory surgical center shall bill and accept as payment in full an amount determined in accordance with [ORS 243.256 and 243.879, if applicable, or] the payment methodology prescribed by the Oregon Health Authority under ORS 442.392.

(2) This section does not apply to type A or type B hospitals, as described in ORS 442.470, or rural critical access hospitals, as defined in ORS 442.470.

SECTION 25. 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.

METRICS AND SCORING SUBCOMMITTEE

SECTION 26. ORS 414.638 is amended to read:

414.638. (1) There is created in the Health Plan Quality Metrics Committee a [nine-member] metrics and scoring subcommittee appointed by the Director of the Oregon Health Authority. The members of the subcommittee serve two-year terms and must include:

(a) Three members at large;

(b) Three individuals with expertise in health [outcomes] **outcome** measures; [and]

(c) Three representatives of coordinated care organizations; **and**

(d) **Two members representing public employees enrolled in health benefit plans described in section 2 or 6 of this 2021 Act.**

(2) The subcommittee shall select, from the health outcome and quality measures identified by the Health Plan Quality Metrics Committee, the health outcome and quality measures applicable to services provided by coordinated care organizations **and by health benefit plans described in sections 2 and 6 of this 2021 Act.** The Oregon Health Authority shall incorporate these measures into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements. The authority shall notify each coordinated care organization of any changes in the measures at least three months before the beginning of the contract period during which the new measures will be in place.

(3) The subcommittee shall evaluate the health outcome and quality measures annually, reporting recommendations based on its findings to the Health Plan Quality Metrics Committee, and adjust the measures to reflect:

- (a) The amount of the global budget for a coordinated care organization;
- (b) Changes in membership of the organization;
- (c) The organization's costs for implementing outcome and quality measures; and

- (d) The community health assessment and the costs of the community health assessment conducted by the organization under ORS 414.575.

(4) The authority shall evaluate on a regular and ongoing basis the outcome and quality measures selected by the subcommittee under this section for members in each coordinated care organization and for members statewide.

CAPTIONS

SECTION 27. The unit captions used in this 2021 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 2021 Act.

OPERATIVE DATES AND REPEALS

SECTION 28. (1) Sections 2 and 6 of this 2021 Act and the amendments to ORS 243.256 and 243.879 by sections 4 and 8 of this 2021 Act apply to plans offered by the Public Employees' Benefit Board and the Oregon Educators Benefit Board for the 2023 plan year.

(2) The amendments to section 2 of this 2021 Act by section 3 of this 2021 Act and the amendments to section 6 of this 2021 Act by section 7 or this 2021 Act become operative on January 1, 2024.

(3) The amendments to section 2 of this 2021 Act by section 9 of this 2021 Act, the amendments to section 6 of this 2021 Act by section 12 of this 2021 Act and the amendments to ORS 243.105, 243.107, 243.125, 243.135, 243.160, 243.163, 243.215, 243.221, 243.864, 243.866, 243.874, 414.638, 442.394 and 442.396 by sections 10, 11 and 13 to 26 of this 2021 Act become operative on January 1, 2026.

SECTION 29. ORS 243.256 and 243.879 are repealed on January 1, 2026.
