

Requested by Representative KOTEK

**PROPOSED AMENDMENTS TO  
HOUSE BILL 2266**

1 In line 2 of the printed bill, before the period insert “; creating new pro-  
2 visions; amending ORS 243.135, 243.256, 243.866 and 243.879; and declaring an  
3 emergency”.

4 Delete lines 4 through 10 and insert:

5 **“SECTION 1.** ORS 243.135, as amended by section 27, chapter 746, Oregon  
6 Laws 2017, is amended to read:

7 “243.135. (1) Notwithstanding any other benefit plan contracted for and  
8 offered by the Public Employees’ Benefit Board, the board shall contract for  
9 a health benefit plan or plans best designed to meet the needs and provide  
10 for the welfare of eligible employees, the state and the local governments.  
11 In considering whether to enter into a contract for a plan, the board shall  
12 place emphasis on:

13 “(a) Employee choice among high quality plans;

14 “(b) A competitive marketplace;

15 “(c) Plan performance and information;

16 “(d) Employer flexibility in plan design and contracting;

17 “(e) Quality customer service;

18 “(f) Creativity and innovation;

19 “(g) Plan benefits as part of total employee compensation;

20 “(h) The improvement of employee health; and

21 “(i) Health outcome and quality measures, described in ORS 413.017 (4),

1 that are reported by the plan.

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

6 “(3) Where appropriate for a contracted and offered health benefit plan,  
7 the board shall provide options under which an eligible employee may ar-  
8 range coverage for family members [*who are not enrolled in another health*  
9 *benefit plan offered by the board or the Oregon Educators Benefit Board. An*  
10 *eligible employee who declines coverage in a health benefit plan offered by the*  
11 *Public Employees’ Benefit Board or the Oregon Educators Benefit Board and*  
12 *who is enrolled as a spouse or family member in another health benefit plan*  
13 *offered by the Public Employees’ Benefit Board or the Oregon Educators*  
14 *Benefit Board may not be paid the employer contribution for the plan that was*  
15 *declined*]. **The board shall impose a surcharge in an amount determined**  
16 **by the board on an eligible employee who arranges coverage for the**  
17 **employee’s spouse or dependent under this subsection if the spouse or**  
18 **dependent has access to medical coverage as an employee in another**  
19 **health benefit plan offered by the board or the Oregon Educators**  
20 **Benefit Board.**

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

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

28 “(6) Transfer of enrollment from one plan to another shall be open to all  
29 eligible employees and their family members under rules adopted by the  
30 board. Because of the special problems that may arise in individual instances

1 under comprehensive group practice plan coverage involving acceptable  
2 provider-patient relations between a particular panel of providers and par-  
3 ticular eligible employees and their family members, the board shall provide  
4 a procedure under which any eligible employee may apply at any time to  
5 substitute a health service benefit plan for participation in a comprehensive  
6 group practice benefit plan.

7 “(7) The board shall evaluate a benefit plan that serves a limited ge-  
8 ographic region of this state according to the criteria described in subsection  
9 (1) of this section.

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

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

17 “(9) *[A carrier or third party administrator that contracts with the board*  
18 *to provide or administer a health benefit plan shall, at least once each plan*  
19 *year,]* **As frequently as is recommended as a commercial best practice**  
20 **by consultants engaged by the board, the board shall** conduct an audit  
21 of the health benefit plan enrollees’ continued eligibility for coverage as  
22 spouses or dependents or any other basis that would affect the cost of the  
23 premium for the plan.

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

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

1       **“SECTION 2.** ORS 243.135, as amended by section 16, chapter 489, Oregon  
2 Laws 2017, and section 27, chapter 746, Oregon Laws 2017, is amended to  
3 read:

4       “243.135. (1) Notwithstanding any other benefit plan contracted for and  
5 offered by the Public Employees’ Benefit Board, the board shall contract for  
6 a health benefit plan or plans best designed to meet the needs and provide  
7 for the welfare of eligible employees, the state and the local governments.  
8 In considering whether to enter into a contract for a plan, the board shall  
9 place emphasis on:

- 10       “(a) Employee choice among high quality plans;
- 11       “(b) A competitive marketplace;
- 12       “(c) Plan performance and information;
- 13       “(d) Employer flexibility in plan design and contracting;
- 14       “(e) Quality customer service;
- 15       “(f) Creativity and innovation;
- 16       “(g) Plan benefits as part of total employee compensation;
- 17       “(h) The improvement of employee health; and
- 18       “(i) Health outcome and quality measures, described in ORS 413.017 (4),  
19 that are reported by the plan.

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

24       “(3) Where appropriate for a contracted and offered health benefit plan,  
25 the board shall provide options under which an eligible employee may ar-  
26 range coverage for family members *[who are not enrolled in another health*  
27 *benefit plan offered by the board or the Oregon Educators Benefit Board. An*  
28 *eligible employee who declines coverage in a health benefit plan offered by the*  
29 *Public Employees’ Benefit Board or the Oregon Educators Benefit Board and*  
30 *who is enrolled as a spouse or family member in another health benefit plan*

1 *offered by the Public Employees' Benefit Board or the Oregon Educators*  
2 *Benefit Board may not be paid the employer contribution for the plan that was*  
3 *declined*]. **The board shall impose a surcharge in an amount determined**  
4 **by the board on an eligible employee who arranges coverage for the**  
5 **employee's spouse or dependent under this subsection if the spouse or**  
6 **dependent has access to medical coverage as an employee in another**  
7 **health benefit plan offered by the board or the Oregon Educators**  
8 **Benefit Board.**

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

13 “(5) In developing any health benefit plan, the board may provide an op-  
14 tion of additional coverage for eligible employees and their family members  
15 at an additional cost or premium.

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

25 “(7) The board shall evaluate a benefit plan that serves a limited ge-  
26 ographic region of this state according to the criteria described in subsection  
27 (1) of this section.

28 “(8)(a) The board shall use payment methodologies in self-insured health  
29 benefit plans offered by the board that are designed to limit the growth in  
30 per-member expenditures for health services to no more than 3.4 percent per

1 year.

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

5 “(9) *[A carrier or third party administrator that contracts with the board*  
6 *to provide or administer a health benefit plan shall, at least once each plan*  
7 *year,]* **As frequently as is recommended as a commercial best practice**  
8 **by consultants engaged by the board, the board shall** conduct an audit  
9 of the health benefit plan enrollees’ continued eligibility for coverage as  
10 spouses or dependents or any other basis that would affect the cost of the  
11 premium for the plan.

12 “(10) If the board spends less than 12 percent of its total medical ex-  
13 penditures in self-insured health benefit plans on payments for primary care,  
14 the board shall implement a plan for increasing the percentage of total  
15 medical expenditures spent on payments for primary care by at least one  
16 percent each year.

17 “(11) No later than February 1 of each year, the board shall report to the  
18 Legislative Assembly on any plan implemented under subsection (10) of this  
19 section and on the board’s progress toward achieving the target of spending  
20 at least 12 percent of total medical expenditures in self-insured health benefit  
21 plans on payments for primary care.

22 **“SECTION 3.** ORS 243.866, as amended by section 28, chapter 746, Oregon  
23 Laws 2017, is amended to read:

24 “243.866. (1) The Oregon Educators Benefit Board shall contract for ben-  
25 efit plans best designed to meet the needs and provide for the welfare of el-  
26 igible employees, the districts and local governments. In considering whether  
27 to enter into a contract for a benefit plan, the board shall place emphasis  
28 on:

29 “(a) Employee choice among high-quality plans;

30 “(b) Encouragement of a competitive marketplace;

1 “(c) Plan performance and information;  
2 “(d) District and local government flexibility in plan design and con-  
3 tracting;  
4 “(e) Quality customer service;  
5 “(f) Creativity and innovation;  
6 “(g) Plan benefits as part of total employee compensation;  
7 “(h) Improvement of employee health; and  
8 “(i) Health outcome and quality measures, described in ORS 413.017 (4),  
9 that are reported by the plan.

10 “(2) The board may approve more than one carrier for each type of benefit  
11 plan offered, but the board shall limit the number of carriers to a number  
12 consistent with adequate service to eligible employees and family members  
13 [*who are not enrolled in another health benefit plan offered by the board or*  
14 *the Public Employees’ Benefit Board. An eligible employee who declines cov-*  
15 *erage in a health benefit plan offered by the Oregon Educators Benefit Board*  
16 *or the Public Employees’ Benefit Board and who is enrolled as a spouse or*  
17 *family member in another health benefit plan offered by the Oregon Educators*  
18 *Benefit Board or the Public Employees’ Benefit Board may not be paid the*  
19 *employer contribution for the plan that was declined*]. **The board shall im-**  
20 **pose a surcharge in an amount determined by the board on an eligible**  
21 **employee who arranges coverage for the employee’s spouse or de-**  
22 **pendent under this subsection if the spouse or dependent has access**  
23 **to medical coverage as an employee in another health benefit plan**  
24 **offered by the board or the Public Employees’ Benefit Board.**

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

28 “(4) A district or a local government shall provide that payroll deductions  
29 for benefit plan costs that are not payable by the district or local govern-  
30 ment may be made upon receipt of a signed authorization from the employee

1 indicating an election to participate in the benefit plan or plans selected and  
2 allowing the deduction of those costs from the employee's pay.

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

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

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

18 “(8) The board shall evaluate a benefit plan that serves a limited ge-  
19 ographic region of this state according to the criteria described in subsection  
20 (1) of this section.

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

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

28 “(10) [*A carrier or third party administrator that contracts with the board*  
29 *to provide or administer a health benefit plan shall, at least once each plan*  
30 *year,*] **As frequently as is recommended as a commercial best practice**



1 **by consultants engaged by the board, the board shall** conduct an audit  
2 of the health benefit plan enrollees' continued eligibility for coverage as  
3 spouses or dependents or any other basis that would affect the cost of the  
4 premium for the plan.

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

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

12 **“SECTION 4.** ORS 243.866, as amended by section 17, chapter 489, Oregon  
13 Laws 2017, and section 28, chapter 746, Oregon Laws 2017, is amended to  
14 read:

15 “243.866. (1) The Oregon Educators Benefit Board shall contract for ben-  
16 efit plans best designed to meet the needs and provide for the welfare of el-  
17 igible employees, the districts and local governments. In considering whether  
18 to enter into a contract for a benefit plan, the board shall place emphasis  
19 on:

20 “(a) Employee choice among high-quality plans;

21 “(b) Encouragement of a competitive marketplace;

22 “(c) Plan performance and information;

23 “(d) District and local government flexibility in plan design and con-  
24 tracting;

25 “(e) Quality customer service;

26 “(f) Creativity and innovation;

27 “(g) Plan benefits as part of total employee compensation;

28 “(h) Improvement of employee health; and

29 “(i) Health outcome and quality measures, described in ORS 413.017 (4),  
30 that are reported by the plan.

1       “(2) The board may approve more than one carrier for each type of benefit  
2 plan offered, but the board shall limit the number of carriers to a number  
3 consistent with adequate service to eligible employees and family members  
4 [*who are not enrolled in another health benefit plan offered by the board or*  
5 *the Public Employees’ Benefit Board. An eligible employee who declines cov-*  
6 *erage in a health benefit plan offered by the Oregon Educators Benefit Board*  
7 *or the Public Employees’ Benefit Board and who is enrolled as a spouse or*  
8 *family member in another health benefit plan offered by the Oregon Educators*  
9 *Benefit Board or the Public Employees’ Benefit Board may not be paid the*  
10 *employer contribution for the plan that was declined*]. **The board shall im-**  
11 **pose a surcharge in an amount determined by the board on an eligible**  
12 **employee who arranges coverage for the employee’s spouse or de-**  
13 **pendent under this subsection if the spouse or dependent has access**  
14 **to medical coverage as an employee in another health benefit plan**  
15 **offered by the board or the Public Employees’ Benefit Board.**

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

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

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

27       “(6) The board shall adopt rules providing that transfer of enrollment  
28 from one benefit plan to another is open to all eligible employees and family  
29 members. Because of the special problems that may arise involving accepta-  
30 ble provider-patient relations between a particular panel of providers and a

1 particular eligible employee or family member under a comprehensive group  
2 practice benefit plan, the board shall provide a procedure under which any  
3 eligible employee may apply at any time to substitute another benefit plan  
4 for participation in a comprehensive group practice benefit plan.

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

9 “(8) The board shall evaluate a benefit plan that serves a limited ge-  
10 ographic region of this state according to the criteria described in subsection  
11 (1) of this section.

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

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

19 “(10) [*A carrier or third party administrator that contracts with the board*  
20 *to provide or administer a health benefit plan shall, at least once each plan*  
21 *year,*] **As frequently as is recommended as a commercial best practice**  
22 **by consultants engaged by the board, the board shall** conduct an audit  
23 of the health benefit plan enrollees’ continued eligibility for coverage as  
24 spouses or dependents or any other basis that would affect the cost of the  
25 premium for the plan.

26 “(11) If the board spends less than 12 percent of its total medical ex-  
27 penditures in self-insured health benefit plans on payments for primary care,  
28 the board shall implement a plan for increasing the percentage of total  
29 medical expenditures spent on payments for primary care by at least one  
30 percent each year.

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

6 **“SECTION 5.** ORS 243.256, as amended by section 29, chapter 746, Oregon  
7 Laws 2017, is amended to read:

8 “243.256. (1) A carrier that contracts with the Public Employees’ Benefit  
9 Board to provide to eligible employees and their dependents a benefit plan  
10 that reimburses the cost of inpatient or outpatient hospital services or sup-  
11 plies shall reimburse a claim for the cost of a hospital service or supply that  
12 is covered by, or is similar to a service or supply that is covered by, the  
13 Medicare program in an amount that does not exceed:

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

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

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

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

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

28 “(3) A provider who is reimbursed in accordance with subsection (1) or  
29 (2) of this section may not charge to or collect from the patient or a person  
30 who is financially responsible for the patient an amount in addition to the

1 reimbursement paid under subsection (1) or (2) of this section other than cost  
2 sharing amounts authorized by the terms of the health benefit plan.

3 “(4) If a carrier or third party administrator does not reimburse claims  
4 on a fee-for-service basis, the payment method used must take into account  
5 the limits specified in subsections (1) and (2) of this section. Such payment  
6 methods include, but are not limited to:

7 “(a) Value-based payments;

8 “(b) Capitation payments; and

9 “(c) Bundled payments.

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

12 “(a) A type A or type B hospital as described in ORS 442.470;

13 “(b) A rural critical access hospital as defined in ORS 315.613; [or]

14 “(c) A hospital:

15 “(A) Located in a county with a population of less than 70,000 on August  
16 15, 2017;

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

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

21 **“(d) A hospital located outside of this state.**

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

24 **“SECTION 6.** ORS 243.879, as amended by section 31, chapter 746, Oregon  
25 Laws 2017, is amended to read:

26 “243.879. (1) A carrier that contracts with the Oregon Educators Benefit  
27 Board to provide to eligible employees and their dependents a benefit plan  
28 that reimburses the cost of inpatient or outpatient hospital services or sup-  
29 plies shall reimburse a claim for the cost of a hospital service or supply that  
30 is covered by, or is similar to a service or supply that is covered by, the

1 Medicare program in an amount that does not exceed:

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

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

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

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

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

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

21 “(4) If a carrier or third party administrator does not reimburse claims  
22 on a fee-for-service basis, the payment method used must take into account  
23 the limits specified in subsections (1) and (2) of this section. Such payment  
24 methods include, but are not limited to:

25 “(a) Value-based payments;

26 “(b) Capitation payments; and

27 “(c) Bundled payments.

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

30 “(a) A type A or type B hospital as described in ORS 442.470;

1 “(b) A rural critical access hospital as defined in ORS 315.613; [or]

2 “(c) A hospital:

3 “(A) Located in a county with a population of less than 70,000 on August  
4 15, 2017;

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

7 “(C) With Medicare payments composing at least 40 percent of the  
8 hospital’s total annual patient revenue[.]; or

9 **“(d) A hospital located outside of this state.**

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

12 **“SECTION 7. The Oregon Health Authority shall report to the**  
13 **committees or interim committees of the Legislative Assembly related**  
14 **to health care no later than December 31, 2019, on:**

15 **“(1) Actions and strategies employed by the Public Employees’**  
16 **Benefit Board and the Oregon Educators Benefit Board to limit the**  
17 **growth in per-member expenditures for health services to 3.4 percent**  
18 **per year or less;**

19 **“(2) Challenges identified by the boards in limiting the growth in**  
20 **per-member expenditures for health services to 3.4 percent per year;**

21 **“(3) Steps taken to maximize the state’s purchasing power and re-**  
22 **duce the total cost of delivering care; and**

23 **“(4) An overview of renewal rates from the upcoming and previous**  
24 **benefit years.**

25 **“SECTION 8. (1) The Public Employees’ Benefit Board shall impose**  
26 **a surcharge under ORS 243.135 (3) for plan years beginning on or after**  
27 **January 1, 2021.**

28 **“(2) The Oregon Educators Benefit Board shall impose a surcharge**  
29 **under ORS 243.866 (2) for plan years beginning on or after January 1,**  
30 **2020.**

1     **“SECTION 9. This 2019 Act being necessary for the immediate**  
2 **preservation of the public peace, health and safety, an emergency is**  
3 **declared to exist, and this 2019 Act takes effect on its passage.”.**

4                                     \_\_\_\_\_