CHAPTER 38

AN ACT HB 4164

Relating to the Oregon Health Insurance Exchange; creating new provisions; amending ORS 243.886, 413.011, 413.033, 741.002, 741.027, 741.101, 741.105, 741.201, 741.220, 741.222, 741.250, 741.310, 741.381, 743.730, 743.822 and 743.826 and section 27, chapter 415, Oregon Laws 2011; and declaring an emergency.

Whereas the Legislative Assembly of the State of Oregon enacted Enrolled Senate Bill 99 (2011) establishing the Oregon Health Insurance Exchange Corporation to operate an exchange to help improve Oregonians' access to quality, affordable health care coverage; and

Whereas the Legislative Assembly delayed the operation of the exchange pending legislative approval of a formal business plan; and

Whereas the Oregon Health Insurance Exchange Corporation submitted a formal business plan to the appropriate legislative committees; and

Whereas the appropriate committees of the Legislative Assembly have approved the formal business plan; now, therefore,

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

OREGON HEALTH INSURANCE EXCHANGE CORPORATION

SECTION 1. ORS 741.002 is amended to read:

741.002. (1) The duties of the Oregon Health Insurance Exchange Corporation are to:

(a) Administer a health insurance exchange in accordance with federal law to make qualified health plans available to individuals and groups throughout this state.

(b) Provide information in writing, through an Internet-based clearinghouse and through a toll-free telephone line that will assist individuals and small businesses in making informed health insurance decisions, including:

(A) The grade of each health plan as determined by the corporation and the grading criteria that were used;

(B) Quality and enrollee satisfaction ratings; and

(C) The comparative costs, benefits, provider networks of health plans and other useful information.

(c) Establish and make available an electronic calculator that allows individuals and employers to determine the cost of coverage after deducting any applicable tax credits or cost-sharing reduction.

(d) Using procedures approved by the corporation's board of directors and adopted by rule by the corporation under ORS 741.310, screen, certify and recertify health plans as qualified health plans according to federal and state standards and ensure that qualified health plans provide choices of coverage.

(e) Decertify or suspend, in accordance with ORS chapter 183, the certification of health plans that fail to meet federal and state standards in order to exclude them from participation in the exchange.

(f) Promote fair competition of carriers participating in the exchange by certifying multiple health plans as qualified under ORS 741.310.

(g) Grade health plans in accordance with criteria established by the United States Secretary of Health and Human Services and by the corporation.

(h) Establish open and special enrollment periods for all enrollees, and monthly enrollment periods for Native Americans in accordance with federal law.

(i) Assist individuals and groups to enroll in qualified health plans, including defined contribution plans as defined in section 414 of the Internal Revenue Code and, if appropriate, collect and remit premiums for such individuals or groups.

(j) Facilitate community-based assistance with enrollment in qualified health plans by awarding grants to entities that are certified as navigators as described in 42 U.S.C. 18031(i).

(k) Provide information to individuals and employers regarding the eligibility requirements for state medical assistance programs and assist eligible individuals and families in applying for and enrolling in the programs.

(L) Provide employers with the names of employees who end coverage under a qualified health plan during a plan year.

(m) Certify the eligibility of an individual for an exemption from the individual responsibility requirement of section 5000A of the Internal Revenue Code.

(n) Provide information to the federal government necessary for individuals who are enrolled in qualified health plans through the exchange to receive tax credits and reduced cost-sharing.

(o) Provide to the federal government:

(A) Information regarding individuals determined to be exempt from the individual responsibility requirement of section 5000A of the Internal Revenue Code;

(B) Information regarding employees who have reported a change in employer;

(C) Information regarding individuals who have ended coverage during a plan year; and

(D) Any other information necessary to comply with federal requirements.

(p) Take any other actions necessary and appropriate to comply with the federal requirements for a health insurance exchange.

(q) Work in coordination with the Oregon Health Authority, the Oregon Health Policy Board and the Department of Consumer and Business Services in carrying out its duties.

(2) The corporation may sue and be sued.

(3) The corporation may:

(a) Acquire, lease, rent, own and manage real property.

(b) Construct, equip and furnish buildings or other structures as are necessary to accommodate the needs of the corporation.

(c) Purchase, rent, lease or otherwise acquire for the corporation's use all supplies, materials, equipment and services necessary to carry out the corporation's duties.

(d) Sell or otherwise dispose of any property acquired under this subsection.

(e) Borrow money and give guarantees to finance its facilities and operations.

(4) Any real property acquired and owned by the corporation under this section shall be subject to ad valorem taxation.

(5) The corporation may not borrow money or give guarantees under subsection (3)(e) of this section unless the obligations of the corporation are payable solely out of the corporation's own resources and do not constitute a pledge of the full faith and credit of the State of Oregon or any of the revenues of this state. The State Treasurer and the State of Oregon may not pay bond-related costs for an obligation incurred by the corporation. A holder of an obligation incurred by the corporation does not have the right to compel the exercise of the taxing power of the state to pay bond-related costs.

[*(5)*] **(6)** The corporation may adopt rules necessary to carry out its mission, duties and functions.

SECTION 2. ORS 741.101 is amended to read:

741.101. [*The Oregon Health Insurance Exchange Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Oregon Health Insurance Exchange Fund shall be credited to the fund. The Oregon Health Insurance Exchange Fund consists of moneys received by the Oregon Health Insurance Exchange Corporation through premiums or the imposition of fees under ORS 741.105 and moneys received as grants under ORS 741.310. Moneys in the fund are continuously appropriated to the Oregon Health Insurance Exchange Corporation for carrying out the purposes of ORS 741.001 to 741.540.*]

(1) As used in this section, "depository" has the meaning given that term in ORS 295.001.

(2) The Oregon Health Insurance Exchange Corporation shall establish one or more accounts in one or more depositories insured by the Federal Deposit Insurance Corporation or the National Credit Union Share Insurance Fund. In a manner consistent with the requirements of ORS 295.001 to 295.108, the corporation shall ensure that sufficient collateral secures any amount of funds on deposit that exceeds the limits of the coverage of the Federal Deposit Insurance Corporation or the National Credit Union Share Insurance Fund. All moneys collected or received by the corporation or placed to the credit of the corporation that are not invested under ORS 741.105 must be deposited to the accounts established under this section, including, but not limited to, moneys received by the corporation through premiums or the imposition of fees under ORS 741.105 and moneys received as grants under ORS 741.310.

SECTION 3. All moneys remaining unexpended in the Oregon Health Insurance Exchange Fund on the effective date of this 2012 Act shall be deposited to an account established by the Oregon Health Insurance Exchange Corporation under ORS 741.101.

SECTION 4. ORS 741.105 is amended to read:

741.105. (1) The Oregon Health Insurance Exchange Corporation board of directors shall establish, and the corporation shall impose and collect, an administrative charge from all insurers and state programs participating in the health insurance exchange in an amount sufficient to cover the costs of grants to navigators certified under ORS 741.002 and to pay the administrative and operational expenses of the corporation in carrying out ORS 741.001 to 741.540. The charge shall be paid in a manner and at intervals prescribed by the board and shall be deposited in [*the Oregon Health Insurance Exchange Fund*] **an account** established in ORS 741.101.

(2) Each insurer's charge shall be based on the number of individuals, excluding individuals enrolled in state programs, who are enrolled in health plans offered by the insurer through the exchange. The assessment on each state program shall be based on the number of individuals enrolled in state programs offered through the exchange. The charge may not exceed:

(a) Five percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is at or below 175,000;

(b) Four percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is above 175,000 and at or below 300,000; and

(c) Three percent of the premium or other monthly charge for each enrollee if the number of enrollees receiving coverage through the exchange is above 300,000.

(3)**(a)** If charges collected under subsection (1) of this section exceed the amounts needed for the administrative and operational expenses of the corporation, the excess moneys collected [*shall*] **may** be held and invested and, with the earnings and interest, used by the corporation to offset future net losses or reduce the administrative costs of the corporation.

(b) Investments made by the corporation under this subsection are:

(A) Limited to investments described in ORS 294.035;

(B) Subject to the investment maturity date limitations described in ORS 294.135; and

(C) Subject to the conduct prohibitions listed in ORS 294.145.

(c) The maximum amount of excess moneys that may be held under this subsection is the total administrative and operational expenses anticipated by

the corporation for a six-month period. Any moneys received that exceed the maximum shall be applied by the corporation to reduce the charges imposed by this section.

(4) Charges shall be based on annual statements and other reports deemed necessary by the corporation and filed by an insurer or state program with the exchange.

(5) In addition to charges imposed under subsection (1) of this section, to the extent permitted by federal law the corporation may impose a fee on insurers and state programs participating in the exchange to cover the cost of commissions of insurance producers that are certified by the corporation to facilitate the participation of individuals and employers in the exchange.

(6) The board shall establish the charges and fees under this section in accordance with ORS 183.310 to 183.410 and in such a manner that will reasonably and substantially accomplish the objective of subsections (1) and (5) of this section.

SECTION 5. ORS 741.201 is amended to read:

741.201. (1) The Oregon Health Insurance Exchange Corporation is under the supervision of an executive director appointed by the corporation board of directors. The executive director serves at the pleasure of the board. The executive director shall be paid a salary as prescribed by the board.

(2) Before assuming the duties of the office, the executive director shall:

(a) Give to the state a fidelity bond, with one or more corporate sureties authorized to do business in this state, in a penal sum prescribed by the Director of the Oregon Department of Administrative Services, but not less than $50,000. The premium for the bond shall be paid from [*the Oregon Health Insurance Exchange Fund*] **an account established under ORS 741.101**.

(b) Subscribe to an oath that the executive director faithfully and impartially will discharge the duties of the office and that the executive director will support the Constitution of the United States and the Constitution of the State of Oregon. The executive director shall file a copy of the signed oath with the Secretary of State.

(3) The executive director [*may establish a line of credit under ORS 293.214 and*] has such other powers as are necessary to carry out the duties of the corporation, subject to policy direction by the board.

(4) The executive director may employ, supervise and terminate the employment of such staff as the executive director deems necessary. The executive director shall prescribe their duties and fix their compensation, in accordance with the personnel policies adopted by the board. Employees of the corporation may not be individuals who are:

(a) Employed by, consultants to or members of a board of directors of:

(A) An insurer or third party administrator;

(B) An insurance producer; or

(C) A health care provider, health care facility or health clinic;

(b) Members, board members or employees of a trade association of:

(A) Insurers or third party administrators; or

(B) Health care providers, health care facilities or health clinics; or

(c) Health care providers, unless they receive no compensation for rendering services as health care providers and do not have ownership interests in professional health care practices.

(5)**(a)** The board shall adopt personnel policies, subject to ORS 236.605 to 236.640, for any transferred public employees. The board may elect to provide for participation in a health benefit plan available to state employees pursuant to ORS 243.105 to 243.285 and may elect to participate in the state deferred compensation plan established under ORS 243.401 to 243.507. If the board so elects, employees of the corporation shall be considered eligible employees for purposes of ORS 243.105 to 243.285 and eligible state employees for purposes of ORS 243.401 to 243.507.

(b) In order to facilitate the development of innovative health benefit plans, the board or the executive director may contract with one or more carriers to offer to employees of the Oregon Health Insurance Exchange Corporation proof of concept health benefit plans approved by the Director of the Department of Consumer and Business Services. A plan offered under this paragraph is not subject to ORS 743.730 to 743.773.

(6) With respect to the Public Employees Retirement System, employees of the corporation shall be considered employees for purposes of ORS chapter 238 and eligible employees for purposes of ORS chapter 238A.

(7) Employees of the corporation may participate in collective bargaining in accordance with ORS 243.650 to 243.782.

SECTION 6. ORS 741.220 is amended to read:

741.220. (1) The Oregon Health Insurance Exchange Corporation shall keep an accurate accounting of the operation and all activities, receipts and expenditures of the corporation and the health insurance exchange.

(2) Beginning after the first 12 months of the operation of the exchange and every 12 months thereafter, the Secretary of State shall conduct a financial audit of the corporation and the [*fund*] **accounts established under ORS 741.101** pursuant to ORS 297.210, which shall include but is not limited to:

(a) A review of the sources and uses of the moneys in the [*fund*] **accounts**;

(b) A review of charges and fees imposed and collected pursuant to ORS 741.105; and

(c) A review of premiums collected and remitted.

(3) Beginning after the first 24 months of the operation of the exchange and every two years thereafter, the Secretary of State shall conduct a

performance audit of the corporation and the exchange.

(4) The corporation board of directors, the executive director of the corporation and employees of the corporation shall cooperate with the Secretary of State in the audits and reviews conducted under subsections (2) and (3) of this section.

(5) The audits shall be conducted using generally accepted accounting principles and any financial integrity requirements of federal authorities.

(6) The cost of the audits required by subsections (2) and (3) of this section shall be paid by the corporation.

(7) The Secretary of State shall issue a report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Oregon Health Authority, the Oregon Health Policy Board, the Department of Consumer and Business Services and appropriate federal authorities on the results of each audit conducted pursuant to this section, including any recommendations for corrective actions. The report shall be available for public inspection, in accordance with the Secretary of State's established rules and procedures governing public disclosure of audit documents.

(8) To the extent the audit requirements under this section are similar to any audit requirements imposed on the corporation by federal authorities, the Secretary of State and the corporation shall make reasonable efforts to coordinate with the federal authorities to promote efficiency and the best use of resources in the timing and provision of information.

(9) Not later than the 90th day after the Secretary of State completes and delivers an audit report issued under subsection (7) of this section, the corporation shall notify the Secretary of State in writing of the corrective actions taken or to be taken, if any, in response to any recommendations in the report. The Secretary of State may extend the 90-day period for good cause.

SECTION 7. ORS 741.250 is amended to read:

741.250. (1) Except as [*otherwise provided by law*] **provided in subsection (6) of this section**, the provisions of ORS 279.835 to 279.855 and ORS chapters 240, 276, 279A, 279B, 279C, 282, 283, 291, 292 and 293 do not apply to the Oregon Health Insurance Exchange Corporation.

(2) In carrying out the duties, functions and powers imposed by law upon the corporation, the corporation board of directors or the executive director of the corporation may contract with any state agency or other qualified person or entity for the performance of such duties, functions and powers as the board or executive director considers appropriate.

(3) ORS 30.210 to 30.250, 30.260 to 30.300, 30.310, 30.312, 30.390 and 30.400 apply to the members of the board, the executive director and employees of the corporation.

(4) Notwithstanding subsection (1) of this section, ORS [*293.235,*] 293.240[*, 293.245, 293.260, 293.262, 293.611, 293.625 and 293.630 apply*] **applies** to the accounts of the corporation.

(5) Notwithstanding subsections (1) and (2) of this section, ORS 243.305, 279A.100 and 659A.012 apply to the members of the board, executive director and employees of the corporation.

(6) ORS 279B.060 (6) and 279B.400 to 279B.425 apply to contracts entered into by the corporation.

LEGISLATIVE APPROVAL OF BUSINESS PLAN FOR OREGON HEALTH INSURANCE EXCHANGE

SECTION 8. Section 27, chapter 415, Oregon Laws 2011, is amended to read:

Sec. 27. [*(1) Section 11 of this 2011 Act becomes operative on the date the Legislative Assembly approves the formal business plan submitted by the Oregon Health Insurance Exchange Corporation under section 5 (9) of this 2011 Act. This subsection does not prohibit the implementation, on or after the effective date of this 2011 Act, of the responsibilities of the Oregon Health Authority or the Oregon Health Insurance Exchange Corporation in administering federal grants received for planning, administration or information technology for the exchange.*]

[*(2)*] The amendments to [*section 11 of this 2011 Act*] **ORS 741.310** by section 12 [*of this 2011 Act*]**, chapter 415, Oregon Laws 2011,** become operative on [*the later of the date the Legislative Assembly approves the formal business plan submitted by the corporation under section 5 (9) of this 2011 Act or*] January 1, 2016.

SCHOOL DISTRICT PARTICIPATION IN HEALTH INSURANCE EXCHANGE

SECTION 9. ORS 243.886 is amended to read:

243.886. (1) Except as provided in subsections (2)**,** [*and*] (3) **and (4)** of this section**,**[*:*]

[*(a)*] a district may not provide or contract for a benefit plan **and eligible employees of districts may not participate in a benefit plan** unless the benefit plan**:**

(a) Is provided and administered by the Oregon Educators Benefit Board under ORS 243.860 to 243.886; **or** [*and*]

[*(b) Eligible employees of a district may participate only in benefit plans provided and administered by the board.*]

(b) On or after October 1, 2015, is offered through the health insurance exchange under ORS 741.310 (1)(b).

(2)(a) Except for community college districts, a district that was self-insured before January 1, 2007, or a district that had an independent health insurance trust established and functioning before January 1, 2007, may provide or contract for benefit plans other than benefit plans provided and administered by the board if the premiums for the benefit plans

provided or contracted for by the district are equal to or less than the premiums for comparable benefit plans provided and administered by the board.

(b) A community college district may provide or contract for benefit plans other than benefit plans provided and administered by the board.

(c) In accordance with procedures adopted by the board to extend benefit plan coverage under ORS 243.864 to 243.874 to eligible employees of a self-insured district, a district with an independent health insurance trust or a community college district, these districts may choose to offer benefit plans that are provided and administered by the board. Once employees of a district participate in benefit plans provided and administered by the board, the district may not thereafter provide or contract for benefit plans other than those provided and administered by the board.

(3)(a) A district that has not offered benefit plans provided and administered by the board before June 23, 2009, may provide or contract for benefit plans other than benefit plans provided and administered by the board if the premiums for the benefit plans provided or contracted for by the district are equal to or less than the premiums for comparable benefit plans provided and administered by the board. Once employees of a district or an employee group within a district participates in benefit plans provided and administered by the board, the district may not thereafter provide or contract for benefit plans for those employees or employee groups other than those provided and administered by the board.

(b) To maintain the exception created in this subsection, the board must perform an actuarial analysis of the district at least once every two years. If requested by the district or a labor organization representing eligible employees of the district, the board shall perform the actuarial analysis annually.

(c) As used in this subsection, "district" does not include a community college district.

(4) Nothing in ORS 243.860 to 243.886 may be construed to expand or contract collective bargaining rights or collective bargaining obligations.

SECTION 10. ORS 741.310 is amended to read:

741.310. (1) The following individuals and groups may purchase qualified health plans through the health insurance exchange:

(a) Beginning January 1, 2014[*, individuals and*]**:**

(A) Individuals and families; and

(B) Employers with no more than 50 employees.

(b) Beginning October 1, 2015, districts and eligible employees of districts that are subject to ORS 243.886, unless their participation is precluded by federal law.

[*(b)*] **(c)** Beginning January 1, 2016, employers with 51 to 100 employees.

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

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

(3) Only an insurer that has a certificate of authority to transact insurance in this state and that meets applicable federal requirements for participating in the exchange may offer a qualified health plan through the exchange. Any qualified health plan must be certified under subsection (4) of this section. Prepaid managed care health services organizations that do not have a certificate of authority to transact insurance may serve only medical assistance recipients through the exchange and may not offer qualified health plans.

(4)**(a)** The Oregon Health Insurance Exchange Corporation shall adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans, including requirements that a qualified health plan provide, at a minimum, essential health benefits and have acceptable consumer and provider satisfaction ratings.

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

(c) The corporation shall consult with stakeholders, including but not limited to representatives of school administrators, school board members and school employees, regarding the plans that may be offered through the exchange to districts and eligible employees of districts under subsection (1)(b) of this section.

(5) Notwithstanding subsection (4) of this section, the corporation shall certify as qualified a dental only health plan as permitted by federal law.

(6) The corporation shall establish one streamlined and seamless application and enrollment process for both the exchange and the state medical assistance program.

(7) The corporation, in collaboration with the appropriate state authorities, may establish risk mediation programs within the exchange.

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

(9) The corporation shall ensure, as required by federal laws, that an insurer charges the same premiums for plans sold through the exchange as for identical plans sold outside of the exchange.

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

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

(b) Navigators certified by the corporation under ORS 741.002.

(11) The corporation is authorized to apply for and accept federal grants, other federal funds and

grants from nongovernmental organizations for purposes of developing, implementing and administering the exchange. Moneys received under this subsection shall be deposited in [*and credited to the Oregon Health Insurance Exchange Fund*] **an account** established under ORS 741.101.

SECTION 11. ORS 741.310, as amended by section 12, chapter 415, Oregon Laws 2011, is amended to read:

741.310. (1) **The following** individuals and [*employers with no more than 100 employees*] **groups** may purchase qualified health plans through the health insurance exchange**:**

(a) Individuals and families;

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

(c) Districts and eligible employees of districts that are subject to ORS 243.886, unless their participation is precluded by federal law.

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

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

(3) Only an insurer that has a certificate of authority to transact insurance in this state and that meets applicable federal requirements for participating in the exchange may offer a qualified health plan through the exchange. Any qualified health plan must be certified under subsection (4) of this section. Prepaid managed care health services organizations that do not have a certificate of authority to transact insurance may serve only medical assistance recipients through the exchange and may not offer qualified health plans.

(4)**(a)** The Oregon Health Insurance Exchange Corporation shall adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans, including requirements that a qualified health plan provide, at a minimum, essential health benefits and have acceptable consumer and provider satisfaction ratings.

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

(c) The corporation shall consult with stakeholders, including but not limited to representatives of school administrators, school board members and school employees, regarding the plans that may be offered through the exchange to districts and eligible employees of districts under subsection (1)(c) of this section.

(5) Notwithstanding subsection (4) of this section, the corporation shall certify as qualified a dental only health plan as permitted by federal law.

(6) The corporation shall establish one streamlined and seamless application and enrollment process for both the exchange and the state medical assistance program.

(7) The corporation, in collaboration with the appropriate state authorities, may establish risk mediation programs within the exchange.

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

(9) The corporation shall ensure, as required by federal laws, that an insurer charges the same premiums for plans sold through the exchange as for identical plans sold outside of the exchange.

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

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

(b) Navigators certified by the corporation under ORS 741.002.

(11) The corporation is authorized to apply for and accept federal grants, other federal funds and grants from nongovernmental organizations for purposes of developing, implementing and administering the exchange. Moneys received under this subsection shall be deposited in [*and credited to the Oregon Health Insurance Exchange Fund*] **an account** established under ORS 741.101.

SECTION 12. The Oregon Health Insurance Exchange Corporation shall apply for a waiver of federal law or any formal permission from the appropriate federal agency or agencies that is necessary to allow districts and eligible employees of districts to obtain health benefit plans through the health insurance exchange in accordance with ORS 243.886.

TECHNICAL AND CONFORMING CHANGES

SECTION 13. ORS 243.886, as amended by section 9 of this 2012 Act, is amended to read:

243.886. (1) Except as provided in subsections (2), (3) and (4) of this section, a district may not provide or contract for a benefit plan and eligible employees of districts may not participate in a benefit plan unless the benefit plan:

(a) Is provided and administered by the Oregon Educators Benefit Board under ORS 243.860 to 243.886; or

(b) [*On or after October 1, 2015,*] Is offered through the health insurance exchange under ORS 741.310 [*(1)(b)*] **(1)(c)**.

(2)(a) Except for community college districts, a district that was self-insured before January 1, 2007, or a district that had an independent health insurance trust established and functioning before January 1, 2007, may provide or contract for benefit plans other than benefit plans provided and administered

by the board if the premiums for the benefit plans provided or contracted for by the district are equal to or less than the premiums for comparable benefit plans provided and administered by the board.

(b) A community college district may provide or contract for benefit plans other than benefit plans provided and administered by the board.

(c) In accordance with procedures adopted by the board to extend benefit plan coverage under ORS 243.864 to 243.874 to eligible employees of a self-insured district, a district with an independent health insurance trust or a community college district, these districts may choose to offer benefit plans that are provided and administered by the board. Once employees of a district participate in benefit plans provided and administered by the board, the district may not thereafter provide or contract for benefit plans other than those provided and administered by the board.

(3)(a) A district that has not offered benefit plans provided and administered by the board before June 23, 2009, may provide or contract for benefit plans other than benefit plans provided and administered by the board if the premiums for the benefit plans provided or contracted for by the district are equal to or less than the premiums for comparable benefit plans provided and administered by the board. Once employees of a district or an employee group within a district participates in benefit plans provided and administered by the board, the district may not thereafter provide or contract for benefit plans for those employees or employee groups other than those provided and administered by the board.

(b) To maintain the exception created in this subsection, the board must perform an actuarial analysis of the district at least once every two years. If requested by the district or a labor organization representing eligible employees of the district, the board shall perform the actuarial analysis annually.

(c) As used in this subsection, "district" does not include a community college district.

(4) Nothing in ORS 243.860 to 243.886 may be construed to expand or contract collective bargaining rights or collective bargaining obligations.

SECTION 14. The amendments to ORS 243.886 by section 13 of this 2012 Act become operative January 1, 2016.

SECTION 15. ORS 413.011 is amended to read:

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

(a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS 413.032 and all of the authority's departmental divisions[*, including the Oregon Health Insurance Exchange described in section 17, chapter 595, Oregon Laws 2009*].

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

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

(d) Establish and continuously refine uniform, statewide health care quality standards for use by all purchasers of health care, third-party payers and health care providers as quality performance benchmarks.

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

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

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

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

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

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

[*(k) Develop and submit a plan to the Legislative Assembly by December 31, 2010, with recommended policies and procedures for the Oregon Health Insurance Exchange developed in accordance with section 17, chapter 595, Oregon Laws 2009.*]

[*(L) Develop and submit a plan to the Legislative Assembly by December 31, 2010, with recommendations for the development of a publicly owned health benefit plan that operates in the exchange under the same rules and regulations as all health insurance plans offered through the exchange, including fully allocated fixed and variable operating and capital costs.*]

[*(m)*] **(k)** By December 31, 2010, investigate and report to the Legislative Assembly, and annually thereafter, on the feasibility and advisability of future changes to the health insurance market in Oregon, including but not limited to the following:

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

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

[*(C) Expansion of the exchange to include a program of premium assistance and to advance reforms of the insurance market.*]

[*(D)*] **(C)** The implementation of a system of interoperable electronic health records utilized by all health care providers in this state.

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

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

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

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

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

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

(3) If the board or the authority is unable to perform, in whole or in part, any of the duties described in ORS 413.006 to 413.042, 413.101 and 741.340 without federal approval, the authority is authorized to request, in accordance with ORS 413.072, waivers or other approval necessary to perform those duties. The authority shall implement any portions of those duties not requiring legislative authority or federal approval, to the extent practicable.

(4) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042, 413.101 and 741.340 and by other statutes.

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

SECTION 16. ORS 413.033 is amended to read:

413.033. (1) The Oregon Health Authority is under the supervision and control of a director, who is responsible for the performance of the duties, functions and powers of the authority.

(2) The Governor shall appoint the Director of the Oregon Health Authority, who holds office at the pleasure of the Governor. The appointment of the director shall be subject to confirmation by the Senate in the manner provided by ORS 171.562 and 171.565.

(3)(a) In addition to the procurement authority granted by ORS 179.040 and 279A.050, the director shall have all powers necessary to effectively and expeditiously carry out the duties, functions and powers vested in the authority by ORS 413.032 [*and section 19, chapter 595, Oregon Laws 2009*], and the duties, functions and powers that are shared by or delegated to the authority with respect to the following agencies:

(A) The Oregon Department of Administrative Services;

(B) The Department of Consumer and Business Services; and

(C) The Department of Human Services.

(b) With respect to procurements and contracts that the authority is authorized to conduct or manage, the director may make procurements on behalf of, and supervise the procurement, establishment and administration of contracts entered into by, the departments described in paragraph (a) of this subsection.

(c) Notwithstanding ORS 279B.085, the director may approve a special procurement under paragraph (b) of this subsection that:

(A) Describes the proposed contracting procedure and the goods or services, or the class of goods or services, to be acquired through the special procurement;

(B) Is unlikely to encourage favoritism in the awarding of public contracts or to substantially diminish competition for public contracts; and

(C) Is reasonably expected to result in substantial cost savings to the authority or to the public.

(d) The director shall give public notice of the approval of a proposed special procurement as provided by the authority by rule. The requirements applicable to the Director of the Oregon Department of Administrative Services under ORS 279B.400 apply to the Director of the Oregon Health Authority with respect to special procurements under this subsection.

(e) Notwithstanding ORS 279C.335, the director may exempt a public improvement contract or a class of public improvement contracts that the authority is authorized to conduct or manage from the competitive bidding requirements of ORS 279C.335 (1) if the director makes the findings described in ORS 279C.335 (2). The provisions in ORS 279C.335 (3) to (8) with respect to the Director of the Oregon Department of Administrative Services apply to the Director of the Oregon Health Authority for exemptions granted by the director under this subsection.

(4) The director shall have the power to obtain such other services as the director considers neces-

sary or desirable, including participation in organizations of state insurance supervisory officials and appointment of advisory committees. A member of an advisory committee so appointed shall receive no compensation for services as a member, but, subject to any other applicable law regulating travel and other expenses of state officers, shall receive actual and necessary travel and other expenses incurred in the performance of official duties.

(5) The director may apply for, receive and accept grants, gifts or other payments, including property or services from any governmental or other public or private person and may make arrangement for the use of the receipts, including the undertaking of special studies and other projects relating to the costs of health care, access to health care, public health and health care reform.

SECTION 17. ORS 741.027 is amended to read:

741.027. (1) The Oregon Health Insurance Exchange Corporation board of directors shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of those offices as the board determines.

(2) A majority of the members of the board constitutes a quorum for the transaction of business.

(3) The board shall meet at least once every three months at a place, day and hour determined by the board. The board shall meet at such other times and places specified by the call of the chairperson or of a majority of the members of the board.

(4)(a) Whenever a member of the board has a conflict of interest on an issue that is before the board, the member shall declare to the board the nature of the conflict and the declaration shall be recorded in the official records of the board. The member may participate in any discussion on the issue but may not vote on the issue.

(b) As used in this subsection:

(A) "Business" has the meaning given that term in ORS 244.020.

(B) "Business with which the member or the member's relative is associated" has the meaning given the term "business with which the person is associated" in ORS 244.020.

(C) "Conflict of interest" means that by taking any action or making any decision or recommendation on an issue, the member, the member's relative, or any business with which the member or the member's relative is associated, would receive a private pecuniary benefit or detriment, unless the pecuniary benefit or detriment would affect to the same degree a class consisting of all consumers of or payers for health care in this state.

(5) A member of the board is entitled to compensation and expenses as provided in ORS 292.495, subject to the availability of funds in [*the Oregon Health Insurance Exchange Fund*] **an account established under ORS 741.101**.

(6) ORS 192.610 to 192.690 apply to the board, to the Individual and Employer Consumer Advisory Committee established by ORS 741.029 and to any advisory and technical committees established by the board under ORS 741.031.

SECTION 18. ORS 741.222 is amended to read:

741.222. (1) The executive director of the Oregon Health Insurance Exchange Corporation shall report to the Legislative Assembly each calendar quarter on:

(a) The financial condition of the health insurance exchange, including actual and projected revenues and expenses of the administrative operations of the exchange and commissions paid to insurance producers out of fees collected under ORS 741.105 (5);

(b) The implementation of the business plan adopted by the corporation board of directors;

(c) The development of the information technology system for the exchange; and

(d) Any other information requested by the leadership of the Legislative Assembly.

(2) The corporation board of directors shall provide to the Legislative Assembly, the Governor, the Oregon Health Authority, the Oregon Health Policy Board and the Department of Consumer and Business Services, not later than April 15 of each year:

(a) A report covering the activities and operations of the corporation during the previous year of operations;

(b) A statement of the financial condition**,** [*of the Oregon Health Insurance Exchange Fund*] as of December 31 of the previous year**, of the accounts established under ORS 741.101**;

(c) A description of the role of insurance producers in the exchange; and

(d) Recommendations, if any, for additional groups to be eligible to purchase qualified health plans through the exchange under ORS 741.310.

SECTION 19. ORS 741.381 is amended to read:

741.381. The activities of insurers working under the direction of the Oregon Health Authority**, the Oregon Health Insurance Exchange Corporation** and the Department of Consumer and Business Services pursuant to ORS 413.011 (1)(j) or participating in the [*Oregon Health Insurance Exchange created under section 17, chapter 595, Oregon Laws 2009,*] **health insurance exchange administered under ORS 741.002** do not constitute a conspiracy or restraint of trade or an illegal monopoly, nor are they carried out for the purposes of lessening competition or fixing prices arbitrarily.

SECTION 20. ORS 743.730, as amended by section 49, chapter 500, Oregon Laws 2011, is amended to read:

743.730. For purposes of ORS 743.730 to 743.773:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743.736, 743.760 or 743.761, based upon the person's examination, including a

review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer and portability health benefit plans.

(2) "Affiliate" of, or person "affiliated" with, a specified person means any carrier who, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with a specified person. For purposes of this definition, "control" has the meaning given that term in ORS 732.548.

(3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee in lieu of a preexisting condition exclusion;

(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

(c) During which no premium shall be charged to the enrollee or late enrollee; and

(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under the plan.

(4) "Basic health benefit plan" means a health benefit plan that provides bronze plan coverage and that is approved by the Department of Consumer and Business Services under ORS 743.736.

(5) "Bona fide association" means an association that meets the requirements of 42 U.S.C. 300gg-91 as amended and in effect on March 23, 2010.

(6) "Bronze plan" means a health benefit plan that meets the criteria for a bronze plan prescribed by the director by rule pursuant to ORS 743.822 (2).

(7) "Carrier," except as provided in ORS 743.760, means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

(8) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon Health Insurance Exchange.

(9) "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the enrollee obtains new coverage.

(10) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(11) "Eligible employee" means an employee who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. "Eligible employee" does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the employer for fewer than 90 days are not eligible employees unless the employer so allows.

(12) "Employee" means any individual employed by an employer.

(13) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group, individual or portability health benefit plan who has enrolled for coverage under the terms of the plan.

(14) "Exchange" means the [*Oregon Health Insurance Exchange established pursuant to section 17, chapter 595, Oregon Laws 2009*] **health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310**.

(15) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

(16) "Financial impairment" means that a carrier is not insolvent and is:

(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(17)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

(A) Group health benefit plans offered to small employers;

(B) Individual health benefit plans; or

(C) Portability health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design or family composition.

(18) "Grandfathered health plan" has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

(19) "Group eligibility waiting period" means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

(20)(a) "Health benefit plan" means any:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Health care service contractor or health maintenance organization subscriber contract; or

(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement de-

fined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

(21) "Health statement" means any information that is intended to inform the carrier or insurance producer of the health status of an enrollee or prospective enrollee in a health benefit plan. "Health statement" includes the standard health statement approved by the director under ORS 743.745.

(22) "Individual coverage waiting period" means a period in an individual health benefit plan during which no premiums may be collected and health benefit plan coverage issued is not effective.

(23) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

(24) "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg as amended and in effect on February 17, 2009;

(b) The individual applies for coverage during an open enrollment period;

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

(d) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

(25) "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

(26) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

(27) "Oregon Medical Insurance Pool" means the pool created under ORS 735.610.

(28) "Preexisting condition exclusion" means a health benefit plan provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of ORS 743.730 to 743.773:

(a) Pregnancy does not constitute a preexisting condition except as provided in ORS 743.766;

(b) Genetic information does not constitute a preexisting condition in the absence of a diagnosis of the condition related to such information; and

(c) Except for coverage under an individual grandfathered health plan, a preexisting condition exclusion may not exclude coverage for services, charges or expenses incurred by an individual who is under 19 years of age.

(29) "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

(30) "Rating period" means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

(31) "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

(32) "Silver plan" means an individual or small group health benefit plan that meets the criteria for a silver plan prescribed by the director by rule pursuant to ORS 743.822 (2).

(33)(a) "Small employer" means an employer that employed an average of at least two but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least two eligible employees on the date on which coverage takes effect under a health benefit plan offered by the employer.

(b) Any person that is treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this subsection.

(c) The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

SECTION 21. ORS 743.822 is amended to read:

743.822. (1) [*As a condition of transacting business in the health benefit plan market in this state,*] **In each individual or small group market in which a carrier offers a health benefit plan through the exchange or outside of the exchange,** a carrier [*shall*] **must** offer to residents of this state bronze and silver plans approved by the Department of Consumer and Business Services as meeting the requirements of subsection (2) of this section**.** [*in each individual and small group market in which the carrier offers a health benefit plan through the Oregon Health Insurance Exchange or outside of the exchange.*]

(2) The Director of the Department of Consumer and Business Services shall prescribe by rule the:

(a) Requirements for a bronze plan to ensure that a bronze plan offered in this state is actuarially equivalent to 60 percent of the full actuarial value of benefits included in the essential health benefits package prescribed by the United States Secretary of Health and Human Services under 42 U.S.C. 18022(a).

(b) Requirements for a silver plan to ensure that a silver plan offered in this state is actuarially equivalent to 70 percent of the full actuarial value of benefits included in the essential health benefits package prescribed by the United States Secretary of Health and Human Services under 42 U.S.C. 18022(a).

(c) Form, level of coverage and benefit design for the bronze and silver plans to be used by carriers in the individual and small group market in this state.

SECTION 22. ORS 743.826 is amended to read:

743.826. A carrier may offer a catastrophic plan only through the [*Oregon Health Insurance Exchange*] **exchange** and only to an individual who:

(1) Is under 30 years of age at the beginning of the plan year; or

(2) Is exempt from any state or federal penalties imposed for failing to maintain minimal essential coverage during the plan year.

SECTION 23. (1) Notwithstanding any other provision of law, ORS 743.822 and 743.826 shall not be considered to have been added to or made a part of ORS 743.730 to 743.773 for the purpose of statutory compilation or for the application of definitions, penalties or administrative provisions applicable to statute sections in that series.

(2) ORS 743.822 and 743.826 are added to and made a part of the Insurance Code.

CAPTIONS

SECTION 24. The unit captions used in this 2012 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 2012 Act.

EMERGENCY CLAUSE

SECTION 25. This 2012 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2012 Act takes effect on its passage.

Approved by the Governor March 8, 2012
Filed in the office of Secretary of State March 12, 2012
Effective date March 8, 2012