

A-Engrossed
House Bill 2266

Ordered by the House June 4
Including House Amendments dated June 4

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of Governor Kate Brown for Oregon Health Authority)

SUMMARY

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

[Requires Oregon Health Policy Board to study changes in health care coverage in Oregon since implementation of Patient Protection and Affordable Care Act and report results of study to interim committees of Legislative Assembly related to health.]

Directs Public Employees' Benefit Board and Oregon Educators Benefit Board to impose surcharge on eligible employee who arranges coverage for spouse or dependent with access to medical coverage as employee in health benefit plan offered by Public Employees' Benefit Board or Oregon Educators Benefit Board.

Directs Public Employees' Benefit Board and Oregon Educators Benefit Board to conduct audit of spouse or dependent coverage eligibility as frequently as is recommended by consultants engaged by boards.

Provides that caps on reimbursements of cost of hospital services or supplies provided to enrollees in health benefit plans offered by Public Employees' Benefit Board and Oregon Educators Benefit Board do not apply to reimbursements paid to hospitals located outside of this state.

Directs Oregon Health Authority to report to committees or interim committees of Legislative Assembly related to health care on certain topics related to Public Employees' Benefit Board and Oregon Educators Benefit Board.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to health care; creating new provisions; amending ORS 243.135, 243.256, 243.866 and
3 243.879; and declaring an emergency.

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

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

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

- 12 (a) Employee choice among high quality plans;
13 (b) A competitive marketplace;
14 (c) Plan performance and information;
15 (d) Employer flexibility in plan design and contracting;
16 (e) Quality customer service;
17 (f) Creativity and innovation;
18 (g) Plan benefits as part of total employee compensation;

NOTE: Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

1 (h) The improvement of employee health; and

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

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

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

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

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

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

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

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

35 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
36 mium amounts paid for contracted health benefit plans to 3.4 percent.

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

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

44 (11) No later than February 1 of each year, the board shall report to the Legislative Assembly
45 on the board's progress toward achieving the target of spending at least 12 percent of total medical

1 expenditures in self-insured health benefit plans on payments for primary care.

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

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

9 (a) Employee choice among high quality plans;

10 (b) A competitive marketplace;

11 (c) Plan performance and information;

12 (d) Employer flexibility in plan design and contracting;

13 (e) Quality customer service;

14 (f) Creativity and innovation;

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

16 (h) The improvement of employee health; and

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

19 (2) The board may approve more than one carrier for each type of plan contracted for and of-
20 fered but the number of carriers shall be held to a number consistent with adequate service to eli-
21 gible employees and their family members.

22 (3) Where appropriate for a contracted and offered health benefit plan, the board shall provide
23 options under which an eligible employee may arrange coverage for family members [*who are not*
24 *enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board.*
25 *An eligible employee who declines coverage in a health benefit plan offered by the Public Employees'*
26 *Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse or family*
27 *member in another health benefit plan offered by the Public Employees' Benefit Board or the Oregon*
28 *Educators Benefit Board may not be paid the employer contribution for the plan that was declined].*
29 **The board shall impose a surcharge in an amount determined by the board on an eligible**
30 **employee who arranges coverage for the employee's spouse or dependent under this sub-**
31 **section if the spouse or dependent has access to medical coverage as an employee in another**
32 **health benefit plan offered by the board or the Oregon Educators Benefit Board.**

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

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

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

45 (7) The board shall evaluate a benefit plan that serves a limited geographic region of this state

1 according to the criteria described in subsection (1) of this section.

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

5 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
6 mium amounts paid for contracted health benefit plans to 3.4 percent.

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

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

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

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

22 243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
23 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
24 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
25 phasis on:

- 26 (a) Employee choice among high-quality plans;
- 27 (b) Encouragement of a competitive marketplace;
- 28 (c) Plan performance and information;
- 29 (d) District and local government flexibility in plan design and contracting;
- 30 (e) Quality customer service;
- 31 (f) Creativity and innovation;
- 32 (g) Plan benefits as part of total employee compensation;
- 33 (h) Improvement of employee health; and
- 34 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
35 plan.

36 (2) The board may approve more than one carrier for each type of benefit plan offered, but the
37 board shall limit the number of carriers to a number consistent with adequate service to eligible
38 employees and family members *[who are not enrolled in another health benefit plan offered by the*
39 *board or the Public Employees' Benefit Board. An eligible employee who declines coverage in a health*
40 *benefit plan offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board*
41 *and who is enrolled as a spouse or family member in another health benefit plan offered by the Oregon*
42 *Educators Benefit Board or the Public Employees' Benefit Board may not be paid the employer con-*
43 *tribution for the plan that was declined].* **The board shall impose a surcharge in an amount de-**
44 **termined by the board on an eligible employee who arranges coverage for the employee's**
45 **spouse or dependent under this subsection if the spouse or dependent has access to medical**

1 **coverage as an employee in another health benefit plan offered by the board or the Public**
2 **Employees' Benefit Board.**

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

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

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

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

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

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

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

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

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

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

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

37 **SECTION 4.** ORS 243.866, as amended by section 17, chapter 489, Oregon Laws 2017, and sec-
38 tion 28, chapter 746, Oregon Laws 2017, is amended to read:

39 243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
40 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
41 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
42 phasis on:

- 43 (a) Employee choice among high-quality plans;
- 44 (b) Encouragement of a competitive marketplace;
- 45 (c) Plan performance and information;

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

2 (e) Quality customer service;

3 (f) Creativity and innovation;

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

5 (h) Improvement of employee health; and

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

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

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

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

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

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

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

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

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

42 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
43 mium amounts paid for contracted health benefit plans to 3.4 percent.

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

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

4 (11) If the board spends less than 12 percent of its total medical expenditures in self-insured
5 health benefit plans on payments for primary care, the board shall implement a plan for increasing
6 the percentage of total medical expenditures spent on payments for primary care by at least one
7 percent each year.

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

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

14 243.256. (1) A carrier that contracts with the Public Employees' Benefit Board to provide to el-
15 igible employees and their dependents a benefit plan that reimburses the cost of inpatient or out-
16 patient hospital services or supplies shall reimburse a claim for the cost of a hospital service or
17 supply that is covered by, or is similar to a service or supply that is covered by, the Medicare
18 program in an amount that does not exceed:

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

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

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

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

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

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

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

39 (a) Value-based payments;

40 (b) Capitation payments; and

41 (c) Bundled payments.

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

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

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

1 (c) A hospital:

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

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

4 and

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

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

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

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

12 243.879. (1) A carrier that contracts with the Oregon Educators Benefit Board to provide to el-
13 igible employees and their dependents a benefit plan that reimburses the cost of inpatient or out-
14 patient hospital services or supplies shall reimburse a claim for the cost of a hospital service or
15 supply that is covered by, or is similar to a service or supply that is covered by, the Medicare
16 program in an amount that does not exceed:

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

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

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

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

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

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

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

37 (a) Value-based payments;

38 (b) Capitation payments; and

39 (c) Bundled payments.

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

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

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

44 (c) A hospital:

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

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

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

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

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

8 **SECTION 7. The Oregon Health Authority shall report to the committees or interim**
9 **committees of the Legislative Assembly related to health care no later than December 31,**
10 **2019, on:**

11 **(1) Actions and strategies employed by the Public Employees' Benefit Board and the**
12 **Oregon Educators Benefit Board to limit the growth in per-member expenditures for health**
13 **services to 3.4 percent per year or less;**

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

16 **(3) Steps taken to maximize the state's purchasing power and reduce the total cost of**
17 **delivering care; and**

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

19 **SECTION 8. (1) The Public Employees' Benefit Board shall impose a surcharge under**
20 **ORS 243.135 (3) for plan years beginning on or after January 1, 2021.**

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

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