Minority Report

B-Engrossed

House Bill 2194

Ordered by the Senate June 5
Including House Amendments dated February 17 and Senate Minority Report Amendments dated June 5

Sponsored by nonconcurring members of the Senate Committee on Health Care and Veterans' Affairs: Senators KRUSE, MORSE

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.

Modifies definition of "medical insurance" for purposes of Oregon Medical Insurance Pool. **Defines "covered life" for purposes related to insurance coverage.** Establishes majority of voting members of Oregon Medical Insurance Pool Board as quorum. **Authorizes board to impose assessment on third party administrators on and after January 1, 2011.** Specifies types of insureds excluded from calculation of assessment. Prohibits coverage of person through Oregon Medical Insurance Pool if public health entity or health care provider pays premium for person and payment reduces financial loss of entity or provider even if reduction of loss is not sole purpose for payment. Modifies requirements for portability health benefit plan coverage under pool by removing requirement to reside in Oregon for 180 days. **Confers jurisdiction on Supreme Court of Oregon for specified challenges to Act.**

A BILL FOR AN ACT

Relating to Oregon Medical Insurance Pool; creating new provisions; and amending ORS 735.605, 735.610, 735.614, 735.615, 735.616, 735.650, 735.756, 744.704 and 744.714.

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

SECTION 1. Section 2 of this 2009 Act is added to and made a part of the Insurance Code.

SECTION 2. "Covered life" means a subscriber, policyholder, certificate holder, spouse, dependent child or any other individual insured under an insurance policy or whose benefits are administered by a third party administrator.

SECTION 3. ORS 735.605 is amended to read:

735.605. As used in ORS 735.600 to 735.650:

(1) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to ORS 735.600 to 735.650.

(2) "Board" means the Oregon Medical Insurance Pool Board.

(3) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer.

(4) "Insurer" means:

(a) Any insurer as defined in ORS 731.106 or fraternal benefit society as defined in ORS 748.106 required to have a certificate of authority to transact health insurance business in this state, and any health care service contractor as defined in ORS 750.005[*, issuing medical insurance in this state on or after September 27, 1987*].

(b) Any reinsurer reinsuring medical insurance in this state [*on or after September 27, 1987*].

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.

(c) To the extent consistent with federal law, any self-insurance arrangement covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state [*on or after September 27, 1987*].

(d) All self-insurance arrangements not covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state [*on or after September 27, 1987*].

(5) "Medical insurance" means [*any health insurance benefits payable on the basis of hospital, surgical or medical expenses incurred and any health care service contractor subscriber contract. Medical insurance does not include accident only, disability income, hospital confinement indemnity, dental or credit insurance, coverage issued as a supplement to liability insurance, coverage issued as a supplement to Medicare, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.*] **insurance of humans against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness or childbirth, or against expense incurred in prevention of sickness, in dental care or optometrical service, and every insurance appertaining thereto, including insurance against the risk of economic loss assumed under a less than fully insured employee health benefit plan. "Medical insurance" does not include workers' compensation coverages.**

(6) "Medicare" means coverage under Part A, Part B and Part D of Title XVIII of the Social Security Act, 42 U.S.C. [*1395*] **1395c** et seq., as amended.

(7) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to ORS 735.600 to 735.650.

(8) "Pool" means the Oregon Medical Insurance Pool as created by ORS 735.610.

(9) "Reinsurer" means any insurer as defined in ORS 731.106 from whom any person providing medical insurance to Oregon insureds procures insurance for itself in the insurer, with respect to all or part of the medical insurance risk of the person. **"Reinsurer" includes an insurer providing insurance against the risk of economic loss.**

(10) "Self-insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide health care services or benefits to their employees or members in this state, either directly or indirectly through a trust or third party administrator, unless the health care services or benefits are provided by an insurance policy issued by an insurer other than a self-insurance arrangement.

(11) "Third party administrator" means any person required to obtain a license pursuant to ORS 744.702.

SECTION 4. ORS 735.610 is amended to read:

735.610. (1) There is created in the Department of Consumer and Business Services the Oregon Medical Insurance Pool Board. The board shall establish the Oregon Medical Insurance Pool and otherwise carry out the responsibilities of the board under ORS 735.600 to 735.650.

(2) The board shall consist of nine individuals, eight of whom shall be appointed by the Director of the Department of Consumer and Business Services. The director [*of the Department of Consumer and Business Services*] or the director's designee shall be [*a*] **the ninth** member of the board. The chair of the board shall be elected from among the members of the board. The board shall at all times, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care

service contractor, one representative of a health maintenance organization, one representative of reinsurers and two members of the general public who are not associated with the medical profession, a hospital or an insurer. **A majority of the voting members of the board constitutes a quorum for the transaction of business. An act by a majority of a quorum is an official act of the board.**

(3) The director may fill any vacancy on the board by appointment.

(4) The board shall have the general powers and authority granted under the laws of this state to insurance companies with a certificate of authority to transact health insurance and the specific authority to:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of ORS 735.600 to 735.650 including the authority to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Recover any assessments [*for, on behalf of, or against insurers;*] **from insurers and reinsurers;**

(c) Take such legal action as is necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, insurance producers′ referral fees, claim reserves or formulas and perform any other actuarial function appropriate to the operation of the pool. Rates may not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(e) Issue policies of insurance in accordance with the requirements of ORS 735.600 to 735.650;

(f) Appoint [*from among insurers*] appropriate actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the board;

(g) Seek advances to effect the purposes of the pool; and

(h) Establish rules, conditions and procedures for reinsuring risks under ORS 735.600 to 735.650.

(5) Each member of the board is entitled to compensation and expenses as provided in ORS 292.495.

(6) The director [*of the Department of Consumer and Business Services*] shall adopt rules, as provided under ORS chapter 183, implementing policies recommended by the board for the purpose of carrying out ORS 735.600 to 735.650.

(7) In consultation with the board, the director shall employ such staff and consultants as may be necessary for the purpose of carrying out responsibilities under ORS 735.600 to 735.650.

SECTION 5. ORS 735.610, as amended by section 4 of this 2009 Act, is amended to read:

735.610. (1) There is created in the Department of Consumer and Business Services the Oregon Medical Insurance Pool Board. The board shall establish the Oregon Medical Insurance Pool and otherwise carry out the responsibilities of the board under ORS 735.600 to 735.650.

(2) The board shall consist of nine individuals, eight of whom shall be appointed by the Director of the Department of Consumer and Business Services. The director or the director′s designee shall be the ninth member of the board. The chair of the board shall be elected from among the members of the board. The board shall at all times, to the extent possible, include at least one representative

of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care service contractor, one representative of a health maintenance organization, one representative of reinsurers and two members of the general public who are not associated with the medical profession, a hospital or an insurer. A majority of the voting members of the board constitutes a quorum for the transaction of business. An act by a majority of a quorum is an official act of the board.

(3) The director may fill any vacancy on the board by appointment.

(4) The board shall have the general powers and authority granted under the laws of this state to insurance companies with a certificate of authority to transact health insurance and the specific authority to:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of ORS 735.600 to 735.650 including the authority to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Recover any assessments from insurers**,** [*and*] reinsurers **and third party administrators**;

(c) Take such legal action as is necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, insurance producers' referral fees, claim reserves or formulas and perform any other actuarial function appropriate to the operation of the pool. Rates may not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(e) Issue policies of insurance in accordance with the requirements of ORS 735.600 to 735.650;

(f) Appoint appropriate actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the board;

(g) Seek advances to effect the purposes of the pool; and

(h) Establish rules, conditions and procedures for reinsuring risks under ORS 735.600 to 735.650.

(5) Each member of the board is entitled to compensation and expenses as provided in ORS 292.495.

(6) The director shall adopt rules, as provided under ORS chapter 183, implementing policies recommended by the board for the purpose of carrying out ORS 735.600 to 735.650.

(7) In consultation with the board, the director shall employ such staff and consultants as may be necessary for the purpose of carrying out responsibilities under ORS 735.600 to 735.650.

SECTION 6. ORS 735.614 is amended to read:

735.614. (1) If the Oregon Medical Insurance Pool Board determines at any time that funds in the Oregon Medical Insurance Pool Account are or will become insufficient for **timely** payment of expenses of the pool [*in a timely manner*], the board shall determine the amount of funds needed and shall impose [*and collect assessments against insurers, as provided in this section, in the amount of the funds determined to be needed.*] **upon and collect from insurers and reinsurers assessments calculated in accordance with subsection (2) of this section.**

(2) [*Each insurer's assessment shall be determined by multiplying the total amount to be assessed by a fraction, the numerator of which equals the number of Oregon insureds and certificate holders*

insured or reinsured by each insurer, and the denominator of which equals the total of all Oregon insureds and certificate holders insured or reinsured by all insurers, all determined as of March 31 each year.] **The board shall calculate the assessment of each insurer and reinsurer based on the total amount needed to ensure timely payment of pool expenses. The board will assess each insurer and reinsurer based on its fractional share of all covered lives in Oregon as of March 31 each year.**

(3) [*The board shall ensure that each insured and certificate holder is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains reinsurance for its insureds and certificate holders to include in its count of insureds and certificate holders all insureds and certificate holders whose coverage is reinsured in whole or part. The board shall allow an insurer who is a reinsurer to exclude from its number of insureds those that have been counted by the primary insurer or the primary reinsurer for the purpose of determining its assessment under this subsection.*] **With respect to an assessment, the board shall count each covered life only once. For that purpose, the board shall obtain counts from:**

(a) An insurer of each covered life under all fully or less than fully insured employee health benefit plans of the insurer;

(b) A third party administrator of each covered life under a self-insurance plan using the third party administrator; and

(c) A reinsurer of each covered life reinsured under self-insurance plans that do not use a third party administrator.

(4) If an individual is covered under a self-insurance plan that does not use a third party administrator or the board cannot identify a third party administrator for the plan, and the individual is reinsured by a reinsurer, the board shall assess the reinsurer for that individual.

[*(4)*] **(5)** Each insurer **or reinsurer** shall pay its assessment [*as required by the board.*] **under this section. Insureds under the following types of coverage, as defined by rule by the board, are excluded in the calculation of the assessment:**

(a) Medicaid;

(b) State Children's Health Insurance Program;

(c) Medicare;

(d) Disability income insurance;

(e) Hospital only insurance;

(f) Dental insurance;

(g) Vision only insurance;

(h) Accident only insurance;

(i) Automobile insurance;

(j) Specific disease insurance;

(k) Medical supplemental plans;

(L) TRICARE;

(m) CHAMPUS;

(n) Prescription drug only plans;

(o) Long term care insurance; and

(p) Federal Employees Health Benefits Program.

[*(5)*] **(6)** If assessments exceed the amounts actually needed, the excess shall be held and invested and, with the earnings and interest, used by the board to offset future net losses or to reduce pool premiums. For purposes of this subsection, "future net losses" includes reserves for claims in-

curred but not reported.

[*(6)*] **(7)** [*Each insurer's proportion of participation in the pool shall be determined by the board*] **The board shall determine the fractional share for each insurer and reinsurer of all covered lives in Oregon** based on annual statements and other reports deemed necessary by the board and filed by the insurer **or reinsurer** with the board **or with the Department of Consumer and Business Services**. The board may use any reasonable method of estimating the number of [*insureds and certificate holders of an insurer*] **covered lives** if the specific number is unknown. [*With respect to insurers that are reinsurers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer.*]

[*(7)*] **(8)** The board may abate or defer, in whole or in part, the assessment [*of an insurer if, in the opinion of the board,*] **calculated under subsection (2) of this section if the board determines that** payment of the assessment would endanger the ability of the insurer **or reinsurer** to fulfill [*the insurer's*] **its** contractual obligations. In the event an assessment [*against an insurer*] is abated or deferred in whole or in part **under this subsection**, the amount by which the assessment is abated or deferred may be assessed against the other [*insurers in a manner consistent with the basis for assessments set forth in this section.*] **insurers and reinsurers subject to the assessment in a manner consistent with subsection (2) of this section.** The insurer **or reinsurer** receiving the abatement or deferment shall remain liable to the board for the deficiency for four years.

[*(8)*] **(9)** The board shall abate or defer assessments authorized by this section if a court orders that assessments cannot be made applicable to reinsurers. However, if a court orders that assessments cannot be made applicable to reinsurers, the board may continue to assess insurers to the end of the biennium in which the determination is made.

[*(9)*] **(10)** Subject to the approval of the Director of the Department of Consumer and Business Services, the board may develop a program for adjusting the assessment of an insurer [*in the individual health benefits market based on that insurer's contribution to reducing the*] **or reinsurer based on the contribution of that insurer or reinsurer to reducing the demand for** enrollment in the Oregon Medical Insurance Pool. When developing the program, the board may consider, but is not limited to, the following factors:

(a) The [*insurer's*] level of participation **of the insurer or reinsurer**;

(b) Level of health benefit plan coverage offered; and

(c) Assumption of risk in the individual health benefits market.

SECTION 7. ORS 735.614, as amended by section 6 of this 2009 Act, is amended to read:

735.614. (1) If the Oregon Medical Insurance Pool Board determines at any time that funds in the Oregon Medical Insurance Pool Account are or will become insufficient for timely payment of expenses of the pool, the board shall determine the amount of funds needed and shall impose upon and collect from insurers**,** [*and*] reinsurers **and third party administrators** assessments calculated in accordance with subsection (2) of this section.

(2) The board shall calculate the assessment of each insurer**,** [*and*] reinsurer **and third party administrator** based on the total amount needed to ensure timely payment of pool expenses. The board will assess each insurer**,** [*and*] reinsurer **and third party administrator** based on its fractional share of all covered lives in Oregon as of March 31 each year.

(3) With respect to an assessment, the board shall count each covered life only once. For that purpose, the board shall obtain counts from:

(a) An insurer of each covered life under all fully or less than fully insured employee health benefit plans of the insurer;

(b) A third party administrator of each covered life under a self-insurance plan using the third party administrator; and

(c) A reinsurer of each covered life reinsured under self-insurance plans that do not use a third party administrator.

(4) If an individual is covered under a self-insurance plan that does not use a third party administrator or the board cannot identify a third party administrator for the plan, and the individual is reinsured by a reinsurer, the board shall assess the reinsurer for that individual.

(5) Each insurer**,** [*or*] reinsurer **and third party administrator** shall pay its assessment under this section. Insureds under the following types of coverage, as defined by rule by the board, are excluded in the calculation of the assessment:

(a) Medicaid;

(b) State Children's Health Insurance Program;

(c) Medicare;

(d) Disability income insurance;

(e) Hospital only insurance;

(f) Dental insurance;

(g) Vision only insurance;

(h) Accident only insurance;

(i) Automobile insurance;

(j) Specific disease insurance;

(k) Medical supplemental plans;

(L) TRICARE;

(m) CHAMPUS;

(n) Prescription drug only plans;

(o) Long term care insurance; and

(p) Federal Employees Health Benefits Program.

(6) If assessments exceed the amounts actually needed, the excess shall be held and invested and, with the earnings and interest, used by the board to offset future net losses or to reduce pool premiums. For purposes of this subsection, "future net losses" includes reserves for claims incurred but not reported.

(7) The board shall determine the fractional share for each insurer**,** [*and*] reinsurer **and third party administrator** of all covered lives in Oregon based on annual statements and other reports deemed necessary by the board and filed by the insurer**,** [*or*] reinsurer **or third party administrator** with the board or with the Department of Consumer and Business Services. The board may use any reasonable method of estimating the number of covered lives if the specific number is unknown.

(8) The board may abate or defer, in whole or in part, the assessment calculated under subsection (2) of this section if the board determines that payment of the assessment would endanger the ability of the insurer**,** [*or*] reinsurer **or third party administrator** to fulfill its contractual obligations. In the event an assessment is abated or deferred in whole or in part under this subsection, the amount by which the assessment is abated or deferred may be assessed against the other insurers**,** [*and*] reinsurers **and third party administrators** subject to the assessment in a manner consistent with subsection (2) of this section. The insurer**,** [*or*] reinsurer **or third party administrator** receiving the abatement or deferment shall remain liable to the board for the deficiency for four years.

(9) [*The board shall abate or defer assessments authorized by this section if a court orders that*

assessments cannot be made applicable to reinsurers. However, if a court orders that assessments cannot be made applicable to reinsurers, the board may continue to assess insurers to the end of the biennium in which the determination is made.] **If a court finds that an assessment imposed on a third party administrator is in violation of federal or state law, the board shall abate or defer the assessment imposed upon the third party administrator but may continue to impose and collect assessments on insurers, reinsurers and other third party administrators.**

(10) Subject to the approval of the Director of the Department of Consumer and Business Services, the board may develop a program for adjusting the assessment of an insurer**,** [*or*] reinsurer **or third party administrator** based on the contribution of that insurer**,** [*or*] reinsurer **or third party administrator** to reducing the demand for enrollment in the Oregon Medical Insurance Pool. When developing the program, the board may consider, but is not limited to, the following factors:

(a) The level of participation of the insurer**,** [*or*] reinsurer **or third party administrator**;

(b) Level of health benefit plan coverage offered; and

(c) Assumption of risk in the individual health benefits market.

SECTION 8. ORS 735.615 is amended to read:

735.615. (1) Except as provided in subsection (3) of this section, a person who is a resident of this state, as defined by the Oregon Medical Insurance Pool Board, is eligible for medical pool coverage if:

(a) An insurer, or an insurance company with a certificate of authority in any other state, has made within a time frame established by the board an adverse underwriting decision, as defined in ORS 746.600 (1)(a)(A), (B) or (D), on individual medical insurance for health reasons while the person was a resident;

(b) The person has a history of any medical or health conditions on the list adopted by the board under subsection (2) of this section;

(c) The person is a spouse or dependent of a person described in paragraph (a) or (b) of this subsection; or

(d) The person is eligible for the credit for health insurance costs under section 35 of the federal Internal Revenue Code, as amended and in effect on December 31, 2004.

(2) The board may adopt a list of medical or health conditions for which a person is eligible for pool coverage without applying for individual medical insurance pursuant to this section.

(3) A person is not eligible for coverage under ORS 735.600 to 735.650 if:

(a) Except as provided in ORS 735.625 (3)(c), the person is eligible to receive health services as defined in ORS 414.705 that meet or exceed those adopted by the board or is eligible for Medicare;

(b) The person has terminated coverage in the pool within the last 12 months and the termination was for:

(A) A reason other than becoming eligible to receive health services as defined in ORS 414.705; or

(B) A reason that does not meet exception criteria established by the board;

(c) The person has exceeded the maximum lifetime benefit established by the board;

(d) The person is an inmate of or a patient in a public institution named in ORS 179.321;

(e) The person has, on the date of issue of coverage by the board, coverage under health insurance or a self-insurance arrangement that is substantially equivalent to coverage under ORS 735.625; or

(f) The person has the premiums paid or reimbursed by a public entity or a health care provider**,** [*for the sole purpose of*] reducing the financial loss or obligation of the payer.

(4) A person applying for coverage shall establish initial eligibility by providing evidence that the board requires.

(5)(a) Notwithstanding ORS 735.625 (4)(c) and subsection (3)(a) of this section, if a person becomes eligible for Medicare after being enrolled in the pool for a period of time as determined by the board by rule, that person may continue coverage within the pool as secondary coverage to Medicare.

(b) The board may adopt rules concerning the terms and conditions for the coverage provided under paragraph (a) of this subsection.

(6) The board may adopt rules to establish additional eligibility requirements for a person described in subsection (1)(d) of this section.

SECTION 9. ORS 735.616 is amended to read:

735.616. **(1) An applicant may qualify for portability health insurance coverage under the Oregon Medical Insurance Pool if:**

(a) An application for coverage is made not later than the 63rd day after the date of first eligibility; and

(b) The individual is an Oregon resident at the time of the application.

[*(1)*] **(2)** In addition to individuals otherwise qualified under ORS 735.615, the following individuals qualify for portability health insurance coverage under the Oregon Medical Insurance Pool [*if an application for coverage is made not later than the 63rd day after the date of first eligibility, as provided in subsection (2) of this section, and the individual is an Oregon resident at the time of such application*]:

(a) An individual who has left coverage that was [*continuously*] in effect for a [*period*] **minimum** of 180 **consecutive** days [*or more*] under one or more group health benefit plans, if[*:*]

[*(A)*] the terminated coverage was in a plan issued or established in a state other than Oregon; [*and*]

[*(B) The individual was an Oregon resident for at least 180 consecutive days immediately prior to the termination of coverage;*]

(b) An eligible individual, as defined in ORS 743.760, who has left coverage under a group health benefit plan or a portability health benefit plan and whose carrier cannot offer a portability plan under ORS 743.760 (6) because of:

(A) A change in residence of the eligible individual within Oregon;

(B) A change in the geographic area served by the group carrier; or

(C) The carrier's withdrawal from the group market in Oregon in accordance with ORS 743.737 and 743.754;

(c) An individual who has left coverage that was [*continuously*] in effect for [*a*] **an uninterrupted** period of 180 days or more under one or more Oregon group health benefit plans and the terminated coverage was provided by:

(A) An employee welfare benefit plan that is exempt from state regulation under the federal Employee Retirement Income Security Act of 1974, as amended;

(B) A multiple employer welfare arrangement subject to ORS 750.301 to 750.341; or

(C) A public body of this state in accordance with ORS 731.036; and

(d) On or after January 1, 1998, an individual who meets the eligibility requirements of 42 U.S.C. 300gg-41, as amended and in effect on January 1, 1998, and does not otherwise qualify to obtain portability coverage from an Oregon group carrier in accordance with ORS 743.760.

[*(2)*] **(3)** Eligibility for coverage pursuant to [*subsection (1)*] **subsections (1) and (2)** of this sec-

tion is subject to the following provisions:

(a) An eligible individual does not include:

(A) An individual who remains eligible for the individual's prior group coverage or would remain eligible for prior group coverage in a plan under the federal Employee Retirement Income Security Act of 1974, as amended, were it not for action by the plan sponsor relating to the actual or expected health condition of the individual;

(B) An individual who is covered under another health benefit plan at the time that portability coverage would commence;

(C) An individual who is eligible to enroll in another health benefit plan offered by the employer, other than as a late enrollee, at the time that portability coverage would commence; or

(D) An individual who is eligible for the federal Medicare program.

(b) If an eligible individual has left group coverage issued by an insurance company, a health care service contractor or a health maintenance organization, the date of first eligibility is the day following the termination date of the group coverage, including any period of continuation coverage that was elected by the individual under federal law or under ORS 743.600 or 743.610.

(c) If an eligible individual has left group coverage issued by an entity other than an insurance company, a health care service contractor or a health maintenance organization, the date of first eligibility is the day following the termination date of the group coverage, including the full extent of continuation coverage available to the individual under federal law and ORS 743.600 and 743.610.

(d) If an individual is eligible for coverage pursuant to subsection [*(1)(b)*] **(2)(b)** of this section, the date of first eligibility is the day following the loss of the group or portability coverage.

[*(3)*] **(4)** Coverage under the Oregon Medical Insurance Pool pursuant to [*subsection (1)*] **subsections (1) and (2)** of this section shall be offered according to the following provisions:

(a) Coverage is subject to ORS 743.760 (2) and (8);

(b) Coverage may not be subject to a preexisting conditions provision, exclusion period, waiting period, residency period or other similar limitation on coverage; and

(c) The individual shall be required to pay a premium rate not more than the applicable portability risk rate determined by the Oregon Medical Insurance Pool Board pursuant to ORS 735.625.

SECTION 10. ORS 735.650 is amended to read:

735.650. (1) The following provisions of the Insurance Code shall apply to the pool to the extent applicable and not inconsistent with the express provisions of ORS 735.600 to 735.650: ORS 731.004 to 731.022, 731.052 to 731.146, 731.162, 731.216 to 731.328, 742.023, 742.028, 742.046, 742.051, 742.056, 743.024, 743.027, 743.028, 743.041, 743.050, 743.100 to 743.106, 743.402, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.834, 743.837, 743.839, 743.845, 743A.084, 743A.090, **744.702, 744.704, 744.724, 744.738,** 746.005 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(2) For the purposes of this section only, the pool shall be deemed an insurer, pool coverage shall be deemed individual health insurance and pool coverage contracts shall be deemed policies.

SECTION 11. ORS 744.704 is amended to read:

744.704. (1) The following persons are exempt from the licensing requirement for third party administrators in ORS 744.702 and from all other provisions of ORS 744.700 to 744.740 applicable to third party administrators:

(a) A person licensed under ORS 744.002 as an adjuster, whose activities are limited to adjustment of claims and whose activities do not include the activities of a third party administrator.

(b) A person licensed as an insurance producer as required by ORS 744.053 and authorized to transact life or health insurance in this state, whose activities are limited exclusively to the sale of insurance and whose activities do not include the activities of a third party administrator.

(c) An employer acting as a third party administrator on behalf of:

(A) Its employees;

(B) The employees of one or more subsidiary or affiliated corporations of the employer; or

(C) The employees of one or more persons with a dealership, franchise, distributorship or other similar arrangement with the employers.

(d) A union, or an affiliate thereof, acting as a third party administrator on behalf of its members.

(e) An insurer that is authorized to transact insurance in this state with respect to a policy issued and delivered in and pursuant to the laws of this state or another state.

(f) A creditor acting on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.

(g) A trust and the trustees, agents and employees of the trust, when acting pursuant to the trust, if the trust is established in conformity with 29 U.S.C. 186.

(h) A trust exempt from taxation under section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to the trust, or a voluntary employees beneficiary association described in section 501(c) of the Internal Revenue Code, its agents and employees and a custodian and the custodian's agents and employees acting pursuant to a custodian account meeting the requirements of section 401(f) of the Internal Revenue Code.

(i) A financial institution that is subject to supervision or examination by federal or state financial institution regulatory authorities, or a mortgage lender, to the extent the financial institution or mortgage lender collects and remits premiums to licensed insurance producers or authorized insurers in connection with loan payments.

(j) A company that issues credit cards and advances for and collects premiums or charges from its credit card holders who have authorized collection. The exemption under this paragraph applies only if the company does not adjust or settle claims.

(k) A person who adjusts or settles claims in the normal course of practice or employment as an attorney at law. The exemption under this subsection applies only if the person does not collect charges or premiums in connection with life insurance or health insurance coverage.

[*(L) A person who acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for which the Insurance Code is preempted pursuant to the Employee Retirement Income Security Act of 1974. A person to whom this paragraph applies must comply with the requirements of ORS 744.714.*]

[*(m)*] **(L)** The Oregon Medical Insurance Pool Board, established under ORS 735.600 to 735.650, and the administering insurer or insurers for the board, for services provided pursuant to ORS 735.600 to 735.650.

[*(n)*] **(m)** An entity or association owned by or composed of like employers who administer partially or fully self-insured plans for employees of the employers or association members.

[*(o)*] **(n)** A trust established by a cooperative body formed between cities, counties, districts or other political subdivisions of this state, or between any combination of such entities, and the trustees, agents and employees acting pursuant to the trust.

[*(p)*] **(o)** Any person designated by the Director of the Department of Consumer and Business Services by rule.

(2) A third party administrator is not required to be licensed as a third party administrator in this state if the following conditions are met:

(a) The third party administrator has its principal place of business in another state;

(b) The third party administrator is not soliciting business as a third party administrator in this state; and

(c) In the case of any group policy or plan of insurance serviced by the third party administrator, the lesser of five percent or 100 certificate holders reside in this state.

SECTION 12. ORS 735.756 is amended to read:

735.756. (1) Of payments made to the Family Health Insurance Assistance Program by the Department of Human Services under ORS 735.754 (4), the department shall determine:

(a) The portion of a subsidy of a subsidized member that is from the General Fund; and

(b) The portion of other costs that is from the General Fund.

(2) The department shall bill the program for the amounts determined under subsection (1) of this section. The program shall forward the bill for the amount determined under subsection (1)(b) of this section to the Oregon Medical Insurance Pool Board.

(3) The board shall:

(a) Determine the amount of funds needed for the payment of other costs under subsection (1)(b) of this section; and

(b) Impose and collect assessments in that amount against insurers, using the methodology described in ORS 735.614 (2), [*(6) and (9)*] **(7) and (10)**.

(4) The board shall pay the program for the amounts determined under subsection (1)(b) of this section.

(5) The program shall forward to the department the amounts determined under subsection (1) of this section.

(6) ORS 735.614 (3), [*(4), (5), (7) and (8)*] **(5), (6), (8) and (9)** applies to assessments collected under this section.

SECTION 13. ORS 744.714 is amended to read:

744.714. A person who is exempt from the requirement of a license as a third party administrator under [*ORS 744.704 because the person acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for which the Insurance Code is preempted pursuant to the Employee Retirement Income Security Act of 1974,*] **ORS 744.702** shall register with the Director of the Department of Consumer and Business Services annually, verifying the status of the person as qualifying for the exemption.

SECTION 14. (1) Jurisdiction is conferred on the Supreme Court to determine in the manner provided by this section whether the provisions of this 2009 Act are preempted by federal law or violate any constitutional provision, including but not limited to impairment of the obligation of contracts under section 21, Article I of the Oregon Constitution, or clause 1, section 10, Article I of the United States Constitution.

(2) A person who is adversely affected by this 2009 Act or who will be adversely affected by this 2009 Act may institute a proceeding for review by filing with the Supreme Court a petition that meets the following requirements:

(a) The petition must be filed within 60 days after the effective date of this 2009 Act or, with respect to the amendments to ORS 735.610 and 735.614 by sections 5 and 7 of this 2009 Act, on or before March 1, 2010.

(b) The petition must include the following:

(A) A statement of the basis of the challenge; and

(B) A statement and supporting affidavit showing how the petitioner is adversely affected.

(3) The petitioner shall serve a copy of the petition by registered or certified mail upon the Department of Consumer and Business Services, the Attorney General and the Governor.

(4) Proceedings for review under this section shall be expedited and given priority over all other matters before the Supreme Court.

(5) In the event the Supreme Court determines that there are factual issues in the petition, the Supreme Court may appoint a special master to hear evidence and to prepare recommended findings of fact.

SECTION 15. The amendments to ORS 735.610 and 735.614 by sections 5 and 7 of this 2009 Act become operative on January 1, 2011.
