

House Bill 2656

Sponsored by Representative BUCKLEY

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 **as introduced**.

Equates mandated health insurance coverage of biological child with mandated health insurance coverage of adopted child.

A BILL FOR AN ACT

1
2 Relating to health insurance coverage of dependent child; creating new provisions; and amending
3 ORS 743.730 and 743A.090.

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

5 **SECTION 1.** ORS 743A.090 is amended to read:

6 743A.090. (1) All individual and group health insurance policies providing hospital, medical or
7 surgical expense benefits that include coverage for a family member of the insured shall also provide
8 that the health insurance benefits [*applicable for children in the family*] shall be payable with respect
9 to:

10 (a) A [*newly born*] **biological** child of the insured from the moment of birth; and

11 (b) An adopted child effective upon placement for adoption.

12 (2) The coverage [*of newly born and adopted children*] required by subsection (1) of this section
13 shall consist of coverage of injury or sickness, including the necessary care and treatment of med-
14 ically diagnosed congenital defects and birth abnormalities.

15 (3) If payment of a specific premium is required to provide coverage for a child, the policy may
16 require that notification of the birth of the child or of the placement for adoption of the child and
17 payment of the premium be furnished the insurer within 31 days after the date of birth or date of
18 placement in order to have the coverage extended beyond the 31-day period.

19 (4) The following requirements apply to coverage of an adopted child required by subsection
20 (1)(b) of this section:

21 (a) In any case in which a policy provides coverage for dependent children of [*participants or*
22 *beneficiaries*] **an insured**, the policy shall provide benefits to dependent children placed with [*par-*
23 *ticipants or beneficiaries*] **an insured** for adoption under the same terms and conditions as apply to
24 the natural, dependent children of the [*participants and beneficiaries*] **insured**, regardless of whether
25 the adoption has become final.

26 (b) A policy may not restrict coverage of any dependent child adopted by [*a participant or ben-*
27 *eficiary*] **an insured**, or placed with [*a participant or beneficiary*] **an insured** for adoption, solely on
28 the basis of a preexisting condition of the child at the time that the child would otherwise become
29 eligible for coverage under the plan if the adoption or placement for adoption occurs while the
30 [*participant or beneficiary*] **insured** is eligible for coverage under the plan.

31 (5) As used in this section:

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 (a) "Child" means[, *in connection with any adoption, or placement for adoption of the child, an*
 2 *individual who has not attained 18 years of age as of the date of the adoption or placement for*
 3 *adoption.*] **an individual who qualifies for coverage as a dependent child under the insured's**
 4 **policy of insurance.**

5 (b) "Placement for adoption" means the assumption and retention by a person of a legal obli-
 6 gation for total or partial support of a child in anticipation of the adoption of the child. The child's
 7 placement with a person terminates upon the termination of such legal obligations.

8 (6) The provisions of ORS 743A.001 do not apply to this section.

9 **SECTION 2.** ORS 743.730 is amended to read:

10 743.730. For purposes of ORS 743.730 to 743.773:

11 (1) "Actuarial certification" means a written statement by a member of the American Academy
 12 of Actuaries or other individual acceptable to the Director of the Department of Consumer and
 13 Business Services that a carrier is in compliance with the provisions of ORS 743.736, 743.760 or
 14 743.761, based upon the person's examination, including a review of the appropriate records and of
 15 the actuarial assumptions and methods used by the carrier in establishing premium rates for small
 16 employer and portability health benefit plans.

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

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

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

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

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

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

30 (4) "Basic health benefit plan" means a health benefit plan for small employers that is required
 31 to be offered by all small employer carriers and approved by the Director of the Department of
 32 Consumer and Business Services in accordance with ORS 743.736.

33 (5) "Bona fide association" means an association that meets the requirements of 42 U.S.C.
 34 300gg-11 as amended and in effect on July 1, 1997.

35 (6) "Carrier" means any person who provides health benefit plans in this state, including a li-
 36 censed insurance company, a health care service contractor, a health maintenance organization, an
 37 association or group of employers that provides benefits by means of a multiple employer welfare
 38 arrangement or any other person or corporation responsible for the payment of benefits or provision
 39 of services.

40 (7) "Committee" means the Health Insurance Reform Advisory Committee created under ORS
 41 743.745.

42 (8) "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as
 43 amended and in effect on July 1, 1997, and includes coverage remaining in force at the time the
 44 enrollee obtains new coverage.

45 (9) "Department" means the Department of Consumer and Business Services.

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

3 (11) "Director" means the Director of the Department of Consumer and Business Services.

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

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

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

14 (15) "Exclusion period" means a period during which specified treatments or services are ex-
 15 cluded from coverage.

16 (16) "Financially impaired" means a member that is not insolvent and is:

17 (a) Considered by the Director of the Department of Consumer and Business Services to be po-
 18 tentially unable to fulfill its contractual obligations; or

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

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

23 (A) Small employer group health benefit plans;

24 (B) Individual health benefit plans; or

25 (C) Portability health benefit plans.

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

28 (18) "Group eligibility waiting period" means, with respect to a group health benefit plan, the
 29 period of employment or membership with the group that a prospective enrollee must complete be-
 30 fore plan coverage begins.

31 (19)(a) "Health benefit plan" means any hospital expense, medical expense or hospital or medical
 32 expense policy or certificate, health care service contractor or health maintenance organization
 33 subscriber contract, any plan provided by a multiple employer welfare arrangement or by another
 34 benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as
 35 amended.

36 (b) "Health benefit plan" does not include coverage for accident only, specific disease or condi-
 37 tion only, credit, disability income, coverage of Medicare services pursuant to contracts with the
 38 federal government, Medicare supplement insurance policies, coverage of CHAMPUS services pur-
 39 suant to contracts with the federal government, benefits delivered through a flexible spending ar-
 40 rangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended,
 41 when the benefits are provided in addition to a group health benefit plan, long term care insurance,
 42 hospital indemnity only, short term health insurance policies (the duration of which does not exceed
 43 six months including renewals), student accident and health insurance policies, dental only, vision
 44 only, a policy of stop-loss coverage that meets the requirements of ORS 742.065, coverage issued as
 45 a supplement to liability insurance, insurance arising out of a workers' compensation or similar law,

1 automobile medical payment insurance or insurance under which benefits are payable with or
2 without regard to fault and that is statutorily required to be contained in any liability insurance
3 policy or equivalent self-insurance.

4 (c) Nothing in this subsection shall be construed to regulate any employee welfare benefit plan
5 that is exempt from state regulation because of the federal Employee Retirement Income Security
6 Act of 1974, as amended.

7 (20) "Health statement" means any information that is intended to inform the carrier or insur-
8 ance producer of the health status of an enrollee or prospective enrollee in a health benefit plan.
9 "Health statement" includes the standard health statement developed by the Health Insurance Re-
10 form Advisory Committee.

11 (21) "Implementation of chapter 836, Oregon Laws 1989" means that the Health Services Com-
12 mission has prepared a priority list, the Legislative Assembly has enacted funding of the list and
13 all necessary federal approval, including waivers, has been obtained.

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

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

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

21 (a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg
22 as amended and in effect on July 1, 1997;

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

24 (c) A court has ordered that coverage be provided for a spouse or minor child under a covered
25 employee's health benefit plan and request for enrollment is made within 30 days after issuance of
26 the court order;

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

29 (e) The individual's coverage under Medicaid, Medicare, CHAMPUS, Indian Health Service or
30 a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan,
31 has been involuntarily terminated within 63 days of applying for coverage in a group health benefit
32 plan.

33 (25) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement
34 as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended,
35 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

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

37 (27) "Preexisting conditions provision" means a health benefit plan provision applicable to an
38 enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during
39 a specified period immediately following enrollment for a condition for which medical advice, diag-
40 nosis, care or treatment was recommended or received during a specified period immediately pre-
41 ceding enrollment. For purposes of ORS 743.730 to 743.773:

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

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

45 (c) A preexisting conditions provision shall not be applied to a [*newborn child or adopted*] child

1 who obtains coverage in accordance with ORS 743A.090.

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

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

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

11 (b) Any person that is treated as a single employer under subsection (b), (c), (m) or (o) of section
12 414 of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this
13 subsection.

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

17 (31) "Small employer carrier" means any carrier that offers health benefit plans covering eligible
18 employees of one or more small employers. A fully insured multiple employer welfare arrangement
19 otherwise exempt under ORS 750.303 (4) may elect to be a small employer carrier governed by the
20 provisions of ORS 743.733 to 743.737.

21 **SECTION 3. The amendments to ORS 743A.090 by section 1 of this 2009 Act apply to**
22 **policies of health insurance issued or renewed on or after the effective date of this 2009 Act.**

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