A-Engrossed
Senate Bill 856

Ordered by the Senate May 8
Including Senate Amendments dated May 8

Sponsored by Senator MONNES ANDERSON

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 Department of Human Services to phase medical assistance recipients into cost containment system of provider contracts.*]

Establishes Oregon Health Authority Board. Specifies composition of board and qualifications for board membership. Specifies duties and powers of board.

Establishes Oregon Health Authority within Department of Human Services. Specifies composition of authority. Specifies duties and powers of authority. Transfers specified duties, functions and powers of Department of Human Services, Office of Private Health Partnerships, Oregon Educators Benefit Board and Public Employees' Benefit Board to authority.

Requires Oregon Health Authority Board to submit to Legislative Assembly report on legislative changes necessary to establish independence of authority on or before June 1, 2010. Requires board to submit to assembly report on legislative changes necessary for board to assume responsibility for health care purchasing functions on or before December 31, 2012.

Establishes Oregon Health Authority Fund. Continuously appropriates moneys in fund to Oregon Health Authority for purpose of carrying out duties of Oregon Health Authority Board and authority.

Creates Quality Care Institute within authority. Directs institute to develop uniform statewide health care quality standards designed for use by purchasers, third-party payers and health care providers.

Requires carrier of health benefit plan and licensed third party administrator to annually submit to Department of Consumer and Business Services data concerning number of covered lives of carrier or administrator.

Directs Health Resources Commission to conduct comparative effectiveness research of certain new and existing health treatments, procedures and services. Directs Health Services Commission to develop or identify evidence-based health care guidelines and to disseminate guidelines to providers, consumers and purchasers of health care.

Specifies procedure by which insurer may file and modify schedule or table of premium rates for individual portability or small employer health insurance.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care cost containment; creating new provisions; amending ORS 65.800, 127.646, 163.206, 243.061, 243.862, 244.050, 409.720, 414.021, 432.500, 442.011, 442.015, 442.700, 678.730, 731.988, 735.701, 735.722, 743.018, 743.730, 743.731, 743.734, 743.736, 743.737, 743.745, 743.760, 743.767, 744.704, 750.055 and 750.333 and section 27, chapter 697, Oregon Laws 2007; repealing ORS 414.031, 442.035, 442.045, 442.057 and 744.714; appropriating money; and declaring an emergency.

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

OREGON HEALTH AUTHORITY BOARD

(Establishment; Appointment; Term; Confirmation; 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.

SECTION 1. (1) There is established the Oregon Health Authority Board, consisting of nine members appointed by the Governor.

(2) The term of office of each member is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(3) The appointment of the board is subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

(4) Members of the board are entitled to compensation and expenses incurred by them in the performance of their official duties in accordance with ORS 292.495.

SECTION 2. Notwithstanding the term of office specified by section 1 of this 2009 Act, of the members first appointed to the Oregon Health Authority Board:

(1) Two shall serve for terms ending December 31, 2011.

(2) Two shall serve for terms ending December 31, 2012.

(3) Two shall serve for terms ending December 31, 2013.

(4) Three shall serve for terms ending December 31, 2014.

(Qualification of Members)

SECTION 3. (1) The Oregon Health Authority Board consists of individuals who:

(a) Are United States citizens and residents of this state;

(b) Have demonstrated leadership skills in their professional and civic lives;

(c) To the greatest extent practicable, represent the various geographic, ethnic, gender, racial and economic diversity of this state; and

(d) Collectively offer expertise, knowledge and experience in consumer advocacy, management of a company that offers health insurance to its employees, public health, finance, organized labor, health care and the operation of a small business.

(2) No more than four members of the board may be individuals:

(a) Whose household incomes, during the individuals′ tenure on the board or during the 12-month period prior to the individuals′ appointment to the board, come from health care or from a health care related field; or

(b) Who receive health care benefits from a publicly funded state health benefit plan.

(3) No more than four members of the board may be, during the individuals′ tenure on the board or during the 12-month period prior to the individuals′ appointment to the board, employed in a health care field or health care related field.

(4) At least one member of the board shall have an active license to provide health care in Oregon and shall be appointed to serve in addition to the members offering the expertise, knowledge and experience described in subsection (1)(d) of this section.

(Officers; Quorum; Meetings)

SECTION 4. (1) The Governor shall select from the membership of the Oregon Health Authority Board the chairperson and vice chairperson.

(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 month and shall meet at least once every two years in each congressional district in this state, at a place, day and hour determined by the board. The board may also meet at other times and places specified by the call of the chairperson or a majority of the members of the board, or as specified in bylaws adopted by the board.

(Authority to Adopt Rules)

SECTION 5. In accordance with applicable provisions of ORS chapter 183, the Oregon Health Authority Board may adopt rules necessary for the administration of the laws that the board is charged with administering.

(Duties)

SECTION 6. (1) The duties of the Oregon Health Authority Board are to:

(a) Be the policy-making and oversight body for the Oregon Health Authority established in section 24 of this 2009 Act and all of the authority's divisions, including the Quality Care Institute described in section 31 of this 2009 Act.

(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) 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.

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

(e) 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.

(f) Review, approve and implement the strategic plan developed by the Health Information Technology Oversight Council established under section 7 of this 2009 Act to support the widespread adoption of interoperable health information technology.

(g) Oversee the efforts of the Health Care Workforce Cooperative established under section 7 of this 2009 Act to ensure that the health care workforce is sufficient in numbers and training to meet the demand that will be created by the expansion in health care coverage, the transformation of the health care system, an increasingly diverse population and an aging workforce. As part of this duty, the board shall create and maintain the health care workforce database described in section 12 of this 2009 Act.

(h) Carry out the provisions of sections 1 to 14, 18, 19, 21 to 24, 26 to 34 and 36 to 44 of this 2009 Act.

(2) Subject to the approval of the Governor, the Oregon Health Authority Board is authorized to organize and reorganize the authority as the board considers necessary to properly conduct the work of the authority.

(3) If the board is unable to perform, in whole or in part, any of the duties described in this section or section 24 of this 2009 Act without federal approval, the board is authorized to request waivers or other approval necessary to perform those duties. The board shall implement any portions of those duties not requiring legislative authority or federal ap-

proval, 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 this section and section 24 of this 2009 Act and by other statutes.

(Council and Cooperatives)

SECTION 7. (1) The Oregon Health Authority Board shall establish the cooperatives and the council described in subsections (2), (3) and (4) of this section. The board shall determine the membership, terms and organization of the cooperatives and the council. Members of the cooperatives and the council who are not members of the board are not entitled to compensation but shall be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by their attendance at meetings of the cooperatives and the council, in the manner and amount provided in ORS 292.495.

(2)(a) The Public Employers Health Cooperative may include any individuals who purchase health care for:

(A) The Public Employees' Benefit Board.

(B) The Oregon Educators Benefit Board.

(C) The state medical assistance program.

(D) The Department of Corrections.

(E) Trustees of the Public Employees Retirement Fund.

(F) A city government.

(G) A county government.

(H) A special district.

(I) Any private nonprofit organization that receives the majority of its funding from the state and requests to participate in the cooperative.

(b) The Public Employers Health Cooperative shall:

(A) Identify and make specific recommendations to ensure that all public health benefit plan designs are based on the best available clinical evidence, recognized best practices for health promotion and disease management, demonstrated cost-effectiveness and shared demographics among the enrollees within the pools covered by the benefit plans.

(B) Develop an action plan for ongoing collaboration to implement the benefit plan design alignment described in subparagraph (A) of this paragraph and shall leverage purchasing to achieve benefit plan uniformity if practicable.

(C) Continually review and report to the Oregon Health Authority Board on the cooperative's progress in aligning benefit plans while minimizing the cost shift to individual purchasers of insurance without shifting costs to the private sector.

(c) The Oregon Health Authority Board shall work with the Public Employers Health Cooperative to identify uniform provisions for state and local public contracts for health benefit plans that achieve maximum quality and cost outcomes. The board shall collaborate with the cooperative to develop steps to implement joint contract provisions. The cooperative shall identify a schedule for the implementation of contract changes. The process for implementation of joint contract provisions must include a review process to protect against unintended cost shifts to enrollees or government agencies.

(3)(a) The Health Care Workforce Cooperative shall coordinate efforts to recruit and ed-

ucate health care professionals and retain a quality workforce to meet the demand that will be created by the expansion in health care coverage, health care system transformations, an increasingly diverse population and an aging workforce.

(b) The Health Care Workforce Cooperative shall guide the Oregon Health Authority Board in creating and maintaining the health care workforce database described in section 12 of this 2009 Act.

(4) The Health Information Technology Oversight Council shall develop a strategic health information technology plan for this state. The plan shall include recommendations for:

(a) Setting specific health information technology goals.

(b) Maximizing the distribution of resources expended on health information technology across this state.

(c) Creating and providing oversight for a public-private purchasing collaborative or alternative mechanism to help small health care practices, primary care providers, rural providers and providers whose practices include a large percentage of medical assistance recipients to obtain affordable rates for high-quality electronic health records hardware, software and technical support for planning, installation, use and maintenance of health information technology.

(d) Identifying and selecting the industry standards for all health information technology promoted by the purchasing collaborative described in paragraph (c) of this subsection, including standards for:

(A) Selecting, supporting and monitoring health information technology vendors, hardware, software and technical support services; and

(B) Ensuring that health information technology applications have appropriate privacy and security controls and that data cannot be used for purposes other than patient care or as otherwise allowed by law.

(e) Enlisting and leveraging community resources to advance the adoption of health information technology.

(f) Educating the public and health care providers on the benefits and risks of health information technology infrastructure investment.

(g) Coordinating health care sector activities that move the adoption of health information technology forward and achieve health information technology interoperability.

(h) Supporting and providing oversight for efforts by the Oregon Health Authority to implement a personal health records bank for medical assistance recipients and assess the bank's potential to serve as a fundamental building block for a statewide health information exchange that:

(A) Ensures that patients' health information is available and accessible when and where patients need it;

(B) Applies only to patients who choose to participate in the exchange; and

(C) Provides meaningful remedies if security or privacy policies are violated.

(i) Determining a fair, appropriate method to reimburse providers for their use of electronic health records to improve patient care, starting with providers whose practices consist of a large percentage of medical assistance recipients.

(j) Determining whether to establish a health information technology loan program and, if so, implementing the program.

(5) Recommendations and plans developed under this section shall be completed by Oc-

tober 1, 2010, and shall be submitted to the Oregon Health Authority Board for approval no later than December 31, 2010.

(Advisory and Technical Committees)

SECTION 8. (1) The Oregon Health Authority Board shall establish the Patient-Centered Primary Care Home Advisory Committee and may establish additional advisory and technical committees that the board considers necessary to aid and advise the board in the performance of the board's functions. The committees may be continuing or temporary committees. The board shall determine the representation, membership, terms and organization of the committees and shall appoint the members of the committees.

(2) Members of the committees who are not members of the board are not entitled to compensation, but at the discretion of the board may be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by them in the performance of their official duties, in the manner and amount provided in ORS 292.495.

(3) The Patient-Centered Primary Care Home Advisory Committee shall advise the board in carrying out the Patient-Centered Primary Care Home Program established in section 9 of this 2009 Act.

(Patient-Centered Primary Care Home Program)

SECTION 9. (1) The Oregon Health Authority Board shall establish and implement the Patient-Centered Primary Care Home Program. As part of the program, the board shall:

(a) In collaboration with the Patient-Centered Primary Care Home Advisory Committee:

(A) Define the core attributes of patient-centered primary care homes to promote consistency in services provided by patient-centered primary care homes in this state.

(B) Establish a simple and uniform process to identify practices that meet the core attributes defined pursuant to subparagraph (A) of this paragraph.

(C) Develop uniform quality measures for patient-centered primary care homes based on nationally accepted quality measures.

(D) Develop uniform quality measures for acute care hospital and ambulatory services that align with the quality measures developed under subparagraph (C) of this paragraph.

(E) Develop policies that encourage the retention of and growth in the number of primary care providers.

(b) Establish a learning collaborative in which state agencies, health insurance carriers, third party administrators and patient-centered primary care homes may:

(A) Share information about quality improvement.

(B) Share best practices that increase the adoption and use of the latest techniques in effective and cost-effective patient-centered integrated health care.

(C) Coordinate efforts to develop and test methods to align financial incentives to support patient-centered primary care homes.

(D) Share best practices for maximizing the utilization of patient-centered primary care homes by individuals enrolled in medical assistance programs, including culturally specific and targeted outreach and direct assistance with applications to adults and children of racial, ethnic and language minority communities and other underserved populations.

(E) Coordinate efforts to conduct research on the patient-centered primary care home model and evaluate strategies to implement the model to improve health status and quality and reduce overall health care costs.

(F) Share best practices for maximizing integration to ensure that patients have access to comprehensive primary care, including preventive and disease management services.

(2) The board may contract with a public or private entity to facilitate the work of the learning collaborative described in subsection (1)(b) of this section and may apply for, receive and accept grants, gifts, payments and other funds and advances, appropriations, properties and services from the United States, the State of Oregon or any governmental body or agency, or from any other public or private corporation or person, for the purpose of establishing and maintaining the collaborative.

(3)(a) As funds are available, the board may develop policies to provide reimbursement in the state's medical assistance program for services provided by patient-centered primary care homes. If practicable, efforts to align financial incentives to support patient-centered integrated health home models of primary care for enrollees in medical assistance programs should be aligned with efforts of the learning collaborative described in subsection (1)(b) of this section.

(b) The policies developed under paragraph (a) of this subsection may reimburse patient-centered primary care homes for interpretive services provided to people in the state's medical assistance programs if interpretive services qualify for federal financial participation.

(c) The policies developed under paragraph (a) of this subsection shall require patient-centered primary care homes receiving reimbursements under this subsection to report to the Oregon Health Authority data on quality measures described in subsection (1)(a)(C) of this section.

(4) The board, in collaboration with members of the learning collaborative established in subsection (1)(b) of this section, the Patient-Centered Primary Care Home Advisory Committee and the Public Employers Health Cooperative, shall:

(a) Develop, test and evaluate strategies that reward enrollees in publicly funded health plans for:

(A) Receiving care through patient-centered primary care homes that meet the core attributes defined by the board under subsection (1) of this section;

(B) Seeking preventive and wellness services;

(C) Practicing healthy behaviors; and

(D) Effectively managing chronic diseases.

(b) Develop, test and evaluate community-based strategies that utilize community health workers to enhance the culturally competent and linguistically appropriate health services provided by patient-centered integrated health home models of primary care in underserved communities.

(5) The board shall focus on patients with chronic health conditions in developing strategies under this section.

(6) The board, in collaboration with the Public Employees' Benefit Board and the Oregon Educators Benefit Board, shall establish uniform standards for contracts with health benefit plans providing coverage to public employees to promote the provision of patient-centered primary care homes, especially for enrollees with chronic medical conditions, that are con-

sistent with the uniform quality measures established by the board under subsection (1)(a)(C) of this section.

(7) The standards established under subsection (6) of this section may direct health benefit plans to provide incentives to primary care providers who serve vulnerable populations to partner with health-focused community-based organizations to provide culturally specific health promotion and disease management services.

(Statewide Health Improvement Program)

SECTION 10. (1) The Oregon Health Authority Board shall establish and implement the Statewide Health Improvement Program to support evidence-based community efforts to prevent chronic disease and reduce the utilization of expensive and invasive acute treatments. The program is composed of activities described in subsections (2) and (3) of this section.

(2) The board shall establish aggressive goals for the reduction of tobacco use, obesity and other chronic disease risk factors. The board shall collaborate with schools, employers and community organizations to develop and implement a strategic plan to achieve the goals.

(3)(a) The board shall award one or more grants to support community-based primary and secondary prevention activities that are focused on chronic diseases and in line with the goals of the Statewide Health Improvement Program.

(b) To receive a grant under this subsection, an applicant must submit a proposal that:

(A) Includes outside funding of at least 10 percent of the total funding required;

(B) Is developed with community input, including the input of communities most impacted by health disparities;

(C) Involves a range of community partners, including a range of multicultural partners;

(D) Is evidence-based;

(E) Reduces health disparities among populations; and

(F) Contains performance criteria and measurable outcomes to demonstrate improvements in population health status and health education and a reduction of chronic disease risk factors.

(Evidence-Based Medicine; Quality Measures; Uniform Contracting)

SECTION 11. (1) The Health Resources Commission established by ORS 442.580 shall conduct comparative effectiveness research of new and existing health treatments, procedures and services, and technologies selected in accordance with ORS 442.583. The commission may conduct the research by comprehensive review of the comparative effectiveness research undertaken by recognized state, national or international entities. The commission shall disseminate the research findings to health care consumers, providers and third-party payers and to other interested stakeholders.

(2) The Health Services Commission established by ORS 414.715 shall develop or identify and shall disseminate evidence-based health care guidelines for use by providers, consumers and purchasers of health care in Oregon.

(3) The Quality Care Institute established by section 31 of this 2009 Act shall develop

uniform quality performance standards described in section 31 of this 2009 Act.

(4) The Oregon Health Authority shall ensure that the work under this section of the Health Services Commission, the Health Resources Commission and the Quality Care Institute is aligned and coordinated.

(5) The Oregon Health Authority Board shall establish evidence-based clinical standards and practice guidelines and uniform quality performance measures based upon the research findings described in subsection (1) of this section, the evidence-based health care guidelines described in subsection (2) of this section and the uniform quality performance standards developed under subsection (3) of this section.

(6) The Public Employers Health Cooperative shall pursue uniform contracting and purchasing strategies that utilize the standards, guidelines and measures established under subsection (5) of this section.

(Health Care Workforce Database)

SECTION 12. (1) The Oregon Health Authority Board shall create and maintain a health care workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's health care workforce, including:

(a) Demographics, including race and ethnicity.

(b) Practice status.

(c) Education and training background.

(d) Population growth.

(e) Economic indicators.

(f) Incentives to attract qualified individuals, especially those from underrepresented minority groups, to health care education.

(2) The board may contract with a private or public entity to establish and maintain the database and to analyze the data. The board is not subject to the requirements of ORS chapters 279A, 279B and 279C with respect to the contract.

SECTION 13. (1) As used in this section, "health care workforce regulatory board" means the:

(a) Occupational Therapy Licensing Board;

(b) Oregon Medical Board;

(c) Oregon State Board of Nursing;

(d) Oregon Board of Dentistry;

(e) Physical Therapist Licensing Board;

(f) State Board of Pharmacy; and

(g) Board of Examiners of Licensed Dietitians.

(2)(a) An applicant for a license from a health care workforce regulatory board or renewal of a license by a health care workforce regulatory board shall provide the information prescribed by the Oregon Health Authority Board pursuant to subsection (3) of this section.

(b) A health care workforce regulatory board may not approve a subsequent application for a license or renewal of a license until the applicant provides the information.

(3) The Oregon Health Authority Board shall collaborate with the health care workforce regulatory boards to adopt rules for the manner, form and content for reporting, and the information that must be provided to a health care workforce regulatory board under sub-

section (2) of this section, which may include:

(a) Demographics, including race and ethnicity.

(b) Education information.

(c) License information.

(d) Employment information.

(e) Primary and secondary practice information.

(f) Anticipated changes in the practice.

(g) Languages spoken.

(4)(a) A health care workforce regulatory board shall report health care workforce information collected under subsection (2) of this section to the Oregon Health Authority Board.

(b) A health care workforce regulatory board shall keep confidential and not release personally identifiable data collected under this section for a person licensed, registered or certified by a board. This paragraph does not apply to the release of information to a law enforcement agency for investigative purposes or to the release to the Oregon Health Authority or the Office for Oregon Health Policy and Research for state health planning purposes as described in ORS 414.021.

(5) The requirements of subsection (2) of this section apply to an applicant for issuance or renewal of a license who is or who is applying to become:

(a) An occupational therapist or occupational therapy assistant as defined in ORS 675.210;

(b) A physician as defined in ORS 677.010;

(c) A physician assistant as defined in ORS 677.495;

(d) A nurse or nursing assistant licensed or certified under ORS 678.010 to 678.410;

(e) A dentist or dental hygienist as defined in ORS 679.010;

(f) A physical therapist or physical therapist assistant as defined in ORS 688.010;

(g) A pharmacist or pharmacy technician as defined in ORS 689.005; or

(h) A licensed dietitian, as defined in ORS 691.405.

(6) A health care workforce regulatory board may adopt rules as necessary to perform the board's duties under this section.

(7) In addition to licensing fees that may be imposed by a health care workforce regulatory board, the board may establish fees to be paid by applicants for issuance or renewal of licenses reasonably calculated to reimburse the actual cost of obtaining or reporting information as required by subsection (2) of this section.

(Administrative Standards)

SECTION 14. (1) The Oregon Health Authority Board shall convene a stakeholder workgroup to develop and approve uniform standards for health insurers licensed in this state, including but not limited to standards for:

(a) Eligibility verification.

(b) Health care claims processes.

(c) Payment and remittance advice.

(2) The Department of Consumer and Business Services shall establish by rule uniform statewide standards for the administrative functions of insurers licensed to provide health insurance in this state. The uniform statewide standards must incorporate the standards

developed under subsection (1) of this section.

(3) The Oregon Health Authority Board shall report on the progress toward the development of uniform standards under subsection (1) of this section to the appropriate interim committees of the Legislative Assembly no later than October 1, 2010.

(Health Insurance Reporting)

SECTION 15. Sections 16 and 17 of this 2009 Act are added to and made a part of the Insurance Code.

SECTION 16. "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 licensed under ORS 744.702.

SECTION 17. (1) A carrier offering a health benefit plan as defined in ORS 743.730 and a third party administrator licensed under ORS 744.702 shall annually submit to the Department of Consumer and Business Services, in a form and manner prescribed by the department, data concerning the number of covered lives of the carrier or third party administrator, reported by line of business and by zip code.

(2) The department shall aggregate the data collected under subsection (1) of this section and may publish reports on the number of covered lives in Oregon, by line of business and by region.

(Insurance Market Reform)

SECTION 18. (1) The Oregon Health Authority Board, in consultation with the Director of the Department of Consumer and Business Services, shall develop and approve one or more standard value-based health benefit plans that:

(a) Promote the provision of health services through patient-centered primary care homes to reduce unnecessary hospitalizations and emergency department visits.

(b) Impose minimal, or no, cost sharing on enrollees for evidence-based preventive care and services, such as care and services that have been shown to prevent acute exacerbations of disease symptoms in individuals with chronic illness.

(c) Create incentives for individuals to actively participate in their own health care and to maintain or improve their health status.

(d) Require a greater contribution by an enrollee to the cost of elective or discretionary health services.

(e) Include a defined set of health care services that are affordable, financially sustainable and based upon the prioritized list of health services developed and updated by the Health Services Commission under ORS 414.720.

(f) Comply with ORS 743.402 to 743.498 for plans offered to individuals.

(g) Comply with ORS 743.730 to 743.773 for plans offered to small employers.

(2) The Oregon Health Authority Board shall implement a program to provide health insurance premium assistance to low and moderate income residents of Oregon.

SECTION 19. An insurer offering a health insurance policy that is subject to ORS 743.402 to 743.498 shall offer one or more standard value-based health benefit plans within 12 months of the approval of the plans by the Oregon Health Authority Board under section 18 of this

2009 Act.

SECTION 19a. The Department of Consumer and Business Services and the advisory committee to the Insurance Division shall develop one or more insurance products designed to provide more affordable options for the small group market.

SECTION 20. ORS 743.736 is amended to read:

743.736. [*(1) In order to improve the availability and affordability of health benefit coverage for small employers, the Health Insurance Reform Advisory Committee created under ORS 743.745 shall submit to the Director of the Department of Consumer and Business Services two basic health benefit plans pursuant to ORS 743.745. One plan shall be in the form of insurance and the second plan shall be consistent with the requirements of the federal Health Maintenance Organization Act, 42 U.S.C. 300e et seq.*]

[*(2)(a) The director shall approve the basic health benefit plans following a determination that the plans provide for maximum accessibility and affordability of needed health care services and following a determination that the basic health benefit plans substantially meet the social values that underlie the ranking of benefits by the Health Services Commission and that the basic health benefit plans are substantially similar to the Medicaid reform program under chapter 836, Oregon Laws 1989, funded by the Legislative Assembly.*]

[*(b) The basic health benefit plans shall include benefits mandated under ORS 743A.168 until mental health, alcohol and chemical dependency services are fully integrated into the Health Services Commission's priority list, and as funded by the Legislative Assembly, and chapter 836, Oregon Laws 1989, is implemented.*]

[*(c) The commission shall aid the director by reviewing the basic health benefit plans and commenting on the extent to which the plans meet these criteria.*]

[*(3)*] **(1)** [*After the director's approval of the basic health benefit plans submitted by the committee pursuant to subsection (1) of this section,*] Each small employer carrier shall submit to the Director **of the Department of Consumer and Business Service** the policy form or forms containing [*its basic*] **a standard value-based** health benefit plan **developed and approved by the Oregon Health Authority under section 18 of this 2009 Act**. Each policy form must be submitted as prescribed by the director and is subject to review and approval pursuant to ORS 742.003.

[*(4)(a)*] **(2)(a)** As a condition of transacting business in the small employer health insurance market in this state, every small employer carrier shall offer small employers [*an approved basic health benefit plan*] **a standard value-based health benefit plan within 12 months of the date of approval of a plan by the authority,** and any other plans that have been submitted by the small employer carrier for use in the small employer market and approved by the director.

(b) Nothing in this subsection shall require a small employer carrier to resubmit small employer health benefit plans that were approved by the director prior to October 1, 1996, nor shall small employer carriers be required to reinitiate new plan selection procedures for currently enrolled small employers prior to the small employer's next health benefit plan coverage anniversary date.

(c) A carrier that offers a health benefit plan in the small employer market only through one or more bona fide associations is not required to offer that health benefit plan to small employers that are not members of the bona fide association.

[*(5)*] **(3)** A small employer carrier shall issue to a small employer any small employer health benefit plan offered by the carrier if the small employer applies for the plan and agrees to make the required premium payments and to satisfy the other provisions of the health benefit plan.

[*(6)*] **(4)** A multiple employer welfare arrangement, professional or trade association or other

similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries shall not issue coverage to a group or individual that is not in the same trade, business, profession or industry as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement shall not include any requirements that relate to the actual or expected health status of the prospective enrollee.

[*(7)*] **(5)** A small employer carrier shall, pursuant to subsections [*(4)*] **(2)** and [*(5)*] **(3)** of this section, offer coverage to or accept applications from a group covered under an existing small employer health benefit plan whether or not a prospective enrollee is excluded from coverage under the existing plan because of late enrollment. When a small employer carrier accepts an application for such a group, the carrier may continue to exclude the prospective enrollee excluded from coverage by the replaced plan until the prospective enrollee would have become eligible for coverage under that replaced plan.

[*(8)*] **(6)** No small employer carrier shall be required to offer coverage or accept applications pursuant to subsections [*(4)*] **(2)** and [*(5)*] **(3)** of this section if the director finds that acceptance of an application or applications would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

[*(9)*] **(7)** Every small employer carrier shall market fairly all small employer health benefit plans offered by the carrier to small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

[*(10)(a)*] **(8)(a)** No small employer carrier shall be required to offer coverage or accept applications pursuant to subsections [*(4)*] **(2)** and [*(5)*] **(3)** of this section in the case of any of the following:

(A) To a small employer if the small employer is not physically located in the carrier's approved service area;

(B) To an employee if the employee does not work or reside within the carrier's approved service areas; or

(C) Within an area where the carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity in its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

(b) A carrier that does not offer coverage pursuant to paragraph (a)(C) of this subsection shall not offer coverage in the applicable service area to new employer groups other than small employers until the carrier resumes enrolling groups of new small employers in the applicable area.

[*(11)*] **(9)** For purposes of ORS 743.733 to 743.737, except as provided in this subsection, carriers that are affiliated carriers or that are eligible to file a consolidated tax return pursuant to ORS 317.715 shall be treated as one carrier and any restrictions or limitations imposed by ORS 743.733 to 743.737 apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier. However, any insurance company or health maintenance organization that is an affiliate of a health care service contractor located in this state, or any health maintenance organization located in this state that is an affiliate of an insurance company or health care service contractor, may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area in this state may be considered a separate carrier.

[*(12)*] **(10)** A small employer carrier that, after September 29, 1991, elects to discontinue offering all of its small employer health benefit plans under ORS 743.737 (5)(e), elects to discontinue renewing all such plans or elects to discontinue offering and renewing all such plans is prohibited from offering health benefit plans in the small employer market in this state for a period of five years from one of the following dates:

(a) The date of notice to the director pursuant to ORS 743.737 (5)(e); or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering small employer health benefit plans in this state.

(Health Insurance Exchange)

SECTION 21. (1) The Oregon Health Authority Board, in consultation with the Director of the Department of Consumer and Business Services, shall develop a detailed business and operational plan for the staffing, funding and administration of a Health Insurance Exchange. The plan shall set forth the duties and responsibilities of the exchange, which shall include, but are not limited to, all of the following:

(a) The selection and pricing of health benefit plans to be offered through the exchange, including a range of price options.

(b) The rating and underwriting standards applicable to the exchange, including whether to incorporate community rating and guaranteed issue.

(c) Determining whether the Public Employees' Benefit Board, the Oregon Educators Benefit Board and other public purchasers will offer coverage through the exchange.

(d) The development of a transition process and timeline for any changes in coverage resulting from the implementation of the exchange.

(e) Establishing enrollment procedures and identifying the role of insurance producers.

(f) Determining whether the exchange will be the exclusive market for individual or small employer purchasers, or whether such purchasers will have other options for obtaining health insurance coverage.

(g) Determining whether and how employees of small employers and employees who are part-time or seasonal workers may access portability plans through the exchange.

(2) The Oregon Health Authority Board shall determine whether to incorporate any of the following into the plan developed under subsection (1) of this section and, if so, how to incorporate:

(a) The use of health savings accounts.

(b) The use of health benefit plans with high deductibles.

(c) To the extent permissible under federal law, the deduction of premiums, deductibles and copayments paid by an employer from the taxable income of an employee.

(3) No later than October 1, 2010, the board shall make a recommendation to the appropriate interim legislative committees for legislative changes necessary to implement the plan developed under this section.

(Studies and Reports to the Legislative Assembly)

SECTION 22. The Oregon Health Authority Board shall study and report to the Legisla-

tive Assembly:

(1) Recommendations for providing health insurance coverage to Oregonians who have health conditions that create a significant risk of high cost insurance claims. The recommendations shall include:

(a) Whether the Oregon Medical Insurance Pool should continue to provide coverage and, if so, how the pool should be funded;

(b) What additional coverage options should be made available and how the options should be funded;

(c) If the Oregon Medical Insurance Pool should not be continued, a transition plan to move the individuals receiving coverage through the pool to other coverage, taking into account the needs of the individuals, including the need for continuity of care; and

(d) Options that utilize reinsurance or other mechanisms to spread risk and stabilize pricing in the individual and small employer markets.

(2) Recommendations regarding a publicly owned health benefit plan option that would be subject to the requirements of the Insurance Code that are applicable to health insurance transacted in this state.

(3) On the feasibility and advisability of a requirement that every Oregon resident obtain and maintain health insurance coverage.

(4) About opportunities to expand health insurance coverage by developing and establishing pilot projects implementing three-share coverage programs that allow employers, employees and state or local government entities to contribute jointly to the cost of employee coverage.

(5) No later than December 31, 2010, on opportunities to utilize the payment system and payment reform as a toll to create incentives in the health care system to provide high quality care.

(6) On opportunities to reform the malpractice liability system in Oregon.

(7) On opportunities to develop a statewide drug formulary to be used by publicly funded health benefit plans.

(8) On other issues that will need to be addressed by comprehensive health care reform in Oregon.

(9) No later than June 1, 2010, legislative changes necessary to establish the Oregon Health Authority as an agency separate from and independent of the Department of Human Services. Under this plan the Department of Human Services shall retain responsibility for providing all or substantially all of the:

(a) Services to senior citizens;

(b) Services to people with disabilities;

(c) Child welfare services;

(d) Public assistance other than medical assistance; and

(e) Other services outside the scope of the duties of the Oregon Health Authority.

SECTION 23. No later than December 31, 2012, the Oregon Health Authority Board shall submit to the Legislative Assembly an implementation plan and a request for legislative changes necessary to assume responsibility for the health care purchasing functions for additional state agencies including, but not limited to:

(1) Agencies responsible for serving senior citizens and persons with disabilities;

(2) Agencies responsible for juvenile justice and juvenile correctional institutions; and

(3) The Department of Corrections and the correctional facilities of the department.

OREGON HEALTH AUTHORITY

(Establishment; Duties; Powers)

SECTION 24. (1) The Oregon Health Authority is established in the Department of Human Services. The authority shall:

(a) Carry out policies adopted by the Oregon Health Authority Board;

(b) Administer the Quality Care Institute created by section 31 of this 2009 Act;

(c) Administer the Oregon Prescription Drug Program;

(d) Administer the Family Health Insurance Assistance Program;

(e) Provide regular reports to the board with respect to the performance of health services contractors serving recipients of medical assistance, including reports of trends in health services and enrollee satisfaction;

(f) Guide and support, with the authorization of the board, community-centered health initiatives designed to address critical behavioral risk factors, especially those that contribute to chronic disease; and

(g) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the Social Security Act and administer medical assistance under ORS chapter 414.

(2) The Oregon Health Authority is authorized to:

(a) Establish and maintain the reporting program described in sections 32 and 33 of this 2009 Act.

(b) Establish and maintain the statewide registry of physician orders for life-sustaining treatment described in section 39 of this 2009 Act.

(3) 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 or vested in the Oregon Health Authority by sections 1 to 14, 18, 19, 21 to 24, 26 to 34 and 36 to 44 of this 2009 Act or by other statutes.

SECTION 25. Section 24 of this 2009 Act is amended to read:

Sec. 24. (1) The Oregon Health Authority is established [*in the Department of Human Services*]. The authority shall:

(a) Carry out policies adopted by the Oregon Health Authority Board;

(b) Administer the Quality Care Institute created by section 31 of this 2009 Act;

(c) Administer the Oregon Prescription Drug Program;

(d) Administer the Family Health Insurance Assistance Program;

(e) Provide regular reports to the board with respect to the performance of health services contractors serving recipients of medical assistance, including reports of trends in health services and enrollee satisfaction;

(f) Guide and support, with the authorization of the board, community-centered health initiatives designed to address critical behavioral risk factors, especially those that contribute to chronic disease; and

(g) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the Social Security Act and administer medical assistance under ORS chapter 414.

(2) The Oregon Health Authority is authorized to:

(a) Establish and maintain the reporting program described in sections 32 and 33 of this 2009 Act.

(b) Establish and maintain the statewide registry of physician orders for life-sustaining treatment described in section 39 of this 2009 Act.

(3) 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 or vested in the Oregon Health Authority by sections 1 to 14, 18, 19, 21 to 24, 26 to 34 and 36 to 44 of this 2009 Act or by other statutes.

(Director)

SECTION 26. (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.

(Deputy Directors)

SECTION 27. (1) The Director of the Oregon Health Authority may, by written order filed with the Secretary of State, appoint deputy directors. A deputy director serves at the pleasure of the director, has authority to act for the director in the absence of the director and is subject to the control of the director at all times.

(2) The director and any deputy directors shall receive such salary as may be provided by law or as fixed by the Governor. In addition to salaries, the director and deputy directors, subject to the limitations otherwise provided by law, shall be reimbursed for all reasonable expenses necessarily incurred in the performance of official duties.

(3) Subject to any applicable provisions of ORS chapter 240, the director shall appoint all subordinate officers and employees of the Oregon Health Authority, prescribe their duties and fix their compensation.

(General Authority to Adopt Rules)

SECTION 28. In accordance with applicable provisions of ORS chapter 183, the Director of the Oregon Health Authority may adopt rules necessary for the administration of the laws that the Oregon Health Authority is charged with administering.

(Oaths, Depositions and Subpoenas)

SECTION 29. The Director of the Oregon Health Authority, each deputy director and authorized representatives of the director may administer oaths, take depositions and issue subpoenas to compel the attendance of witnesses and the production of documents or other written information necessary to carry out the provisions of sections 1 to 14, 18, 19, 21 to 24, 26 to 34 and 36 to 44 of this 2009 Act. If any person fails to comply with a subpoena issued

under this section or refuses to testify on matters on which the person lawfully may be interrogated, the director, deputy director or authorized representative may follow the procedure set out in ORS 183.440 to compel obedience.

(Establishment of Oregon Health Authority Fund)

SECTION 30. The Oregon Health Authority Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Oregon Health Authority Fund shall be credited to the fund. Moneys in the fund are continuously appropriated to the Oregon Health Authority for carrying out the duties of the Oregon Health Authority Board and the Oregon Health Authority under sections 6 and 24 of this 2009 Act.

(Quality Care Institute)

SECTION 31. (1) The Quality Care Institute is created within the Oregon Health Authority.

(2) The institute shall develop, for the Oregon Health Authority Board, uniform statewide health care quality standards that are designed for use by purchasers, third-party payers and health care providers as the quality performance benchmarks in Oregon.

(Health Care Data Reporting)

SECTION 32. As used in sections 33 and 34 of this 2009 Act, "reporting entity" means:

(1) An insurer as defined in ORS 731.106 or fraternal benefit society as described in ORS 748.106 required to have a certificate of authority to transact health insurance business in this state.

(2) A health care service contractor as defined in ORS 750.005 that issues medical insurance in this state.

(3) A third party administrator required to obtain a license under ORS 744.702.

(4) A pharmacy benefit manager or fiscal intermediary, or other person that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service.

(5) A prepaid managed care health services organization as defined in ORS 414.736.

(6) An insurer providing coverage funded under Part A, Part B or Part D of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., subject to approval by the United States Department of Health and Human Services.

SECTION 33. (1) The Oregon Health Authority shall establish and maintain a program that requires reporting entities to report health care information for the following purposes:

(a) Determining the maximum capacity and distribution of existing resources allocated to health care.

(b) Identifying the demands for health care.

(c) Allowing health care policymakers to make informed choices.

(d) Evaluating the effectiveness of intervention programs in improving health outcomes.

(e) Comparing the costs and effectiveness of various treatment settings and approaches.

(f) Providing information to consumers and purchasers of health care.

(g) Improving the quality and affordability of health care and health care coverage.

(h) Assisting the authority in furthering the health policies expressed by the Legislative Assembly in ORS 442.025.

(2) The authority shall adopt rules establishing the time, place, form and manner of reporting health care information under this section, including but not limited to:

(a) Requiring the use of unique patient and provider identifiers; and

(b) Specifying a uniform coding system that reflects all health care utilization, costs and resources in this state, and health care utilization and costs for health care services provided to Oregon residents in other states.

(3) The authority shall adopt rules establishing the types of health care information to be reported under this section, including but not limited to:

(a) Health care claims and enrollment information used by reporting entities and paid health care claims data; and

(b) Reports, data, schedules, statistics or other information relating to health care costs, prices, quality, utilization or resources determined by the authority to be necessary to carry out the purposes of this section.

(4) The authority shall use health care information collected under this section to provide information to consumers of health care to empower the consumers to make economically sound and medically appropriate decisions. The information must include, but not be limited to, the prices and quality of health care services.

(5) The authority may contract with a third party to collect and process the health care information reported under this section. The contract must prohibit the collection of Social Security numbers and must prohibit the disclosure or use of the information for any purpose other than those specifically authorized by the contract. The contract must require the third party to transmit all information collected and processed under the contract to the Office for Oregon Health Policy and Research.

(6) The authority shall facilitate a collaboration among the Department of Human Services, the Department of Consumer and Business Services and interested stakeholders to develop a comprehensive health care information system using the health care information reported under this section and collected by the office under ORS 442.120 and 442.400 to 442.463. The authority, in consultation with interested stakeholders, shall:

(a) Formulate the data sets that will be included in the system;

(b) Establish the criteria and procedures for the development of limited use data sets;

(c) Establish the criteria and procedures to ensure that limited use data sets are accessible and compliant with federal and state privacy laws; and

(d) Establish a time frame for the creation of the comprehensive health care information system.

(7) Information disclosed through the comprehensive health care information system described in subsection (6) of this section:

(a) Shall be available as a resource to state agencies to allow for continuous review of health care utilization, expenditures and performance in this state;

(b) Shall be available to Oregon programs for quality in health care for use in improving health care in Oregon, subject to rules prescribed by the Administrator of the Office for Oregon Health Policy and Research conforming to state and federal privacy laws or limiting access to limited use data sets;

(c) Shall be presented to allow for comparisons of geographic, demographic and economic factors and institutional size;

(d) May not disclose any health care information that contains direct personal identifiers such as names, addresses, electronic mail addresses, telephone numbers or Social Security numbers; and

(e) May not disclose trade secrets of reporting entities.

(8) The collection, storage and release of health care information under this section is subject to the requirements of the federal Health Insurance Portability and Accountability Act.

SECTION 34. (1) Any reporting entity that fails to report as required by section 33 of this 2009 Act or by rules of the Oregon Health Authority adopted pursuant to section 33 of this 2009 Act shall be subject to a civil penalty.

(2) The authority shall adopt a schedule of penalties not to exceed $500 per day of violation, determined by the severity of the violation.

(3) Civil penalties under this section shall be imposed as provided in ORS 183.745.

(4) Civil penalties imposed under this section may be remitted or mitigated upon such terms and conditions as the authority considers proper and consistent with the public health and safety.

(5) Civil penalties incurred under any law of this state are not allowable as costs for the purpose of rate determination or for reimbursement by a third-party payer.

SECTION 35. ORS 731.988 is amended to read:

731.988. (1) [*Any person who violates any provision of the Insurance Code, any lawful rule or final order of the Director of the Department of Consumer and Business Services or any judgment made by any court upon application of the director, shall forfeit and pay to the General Fund of the State Treasury a civil penalty in an amount determined by the director of not more than $10,000 for each offense. In the case of individual insurance producers, adjusters or insurance consultants, the civil penalty shall be not more than $1,000 for each offense. Each violation shall be deemed a separate offense.*] **A person shall forfeit and pay to the General Fund of the State Treasury a civil penalty in an amount determined by the Director of the Department of Consumer and Business Services of not more than $10,000 for each violation of:**

(a) Any provision of the Insurance Code;

(b) Any lawful rule or final order of the director;

(c) Any judgment made by a court upon application made by the director; or

(d) Any rule adopted by the Oregon Health Authority for the reporting of health care information pursuant to section 33 of this 2009 Act.

(2) In addition to the civil penalty set forth in subsection (1) of this section, any person who violates any provision of the Insurance Code, any lawful rule or final order of the director or any judgment made by any court upon application of the director, may be required to forfeit and pay to the General Fund of the State Treasury a civil penalty in an amount determined by the director but not to exceed the amount by which such person profited in any transaction which violates any such provision, rule, order or judgment.

(3) In addition to the civil penalties set forth in subsections (1) and (2) of this section, any insurer that is required to make a report under ORS 742.400 and that fails to do so within the specified time may be required to pay to the General Fund of the State Treasury a civil penalty in an amount determined by the director but not to exceed $10,000.

(4) A civil penalty imposed under this section may be recovered either as provided in subsection (5) of this section or in an action brought in the name of the State of Oregon in any court of appropriate jurisdiction.

(5) Civil penalties under this section shall be imposed and enforced in the manner provided by ORS 183.745.

(6) The provisions of this section are in addition to and not in lieu of any other enforcement provisions contained in the Insurance Code.

(Registry of Physician Orders for Life-Sustaining Treatment)

SECTION 36. Sections 37 to 44 of this 2009 Act shall be known and may be cited as the Oregon POLST Registry Act.

SECTION 37. As used in sections 37 to 44 of this 2009 Act:

(1) "Authorized user" means a person authorized by the Oregon Health Authority to provide information to or receive information from the POLST registry.

(2) "Life-sustaining treatment" means any medical procedure, pharmaceutical, medical device or medical intervention that maintains life by sustaining, restoring or supplanting a vital function. "Life-sustaining treatment" does not include routine care necessary to sustain patient cleanliness and comfort.

(3) "Nurse practitioner" has the meaning given that term in ORS 678.010.

(4) "Physician" has the meaning given that term in ORS 677.010.

(5) "Physician assistant" has the meaning given that term in ORS 677.495.

(6) "POLST" means a physician order for life-sustaining treatment signed by a physician, nurse practitioner or physician assistant.

(7) "POLST registry" means the registry established under section 39 of this 2009 Act.

SECTION 38. Nothing in sections 37 to 44 of this 2009 Act is intended to require an individual to have a POLST or to require a health professional to authorize or execute a POLST. A POLST may be revoked at any time.

SECTION 39. (1) The Oregon Health Authority shall establish and operate a statewide registry for the collection and dissemination of physician orders for life-sustaining treatment to help ensure that medical treatment preferences for an individual nearing the end of the individual's life are honored.

(2) The authority shall adopt rules for the registry, including but not limited to rules that:

(a) Require submission of the following documents to the registry, unless the patient has requested to opt out of the registry:

(A) A copy of each POLST;

(B) A copy of a revised POLST; and

(C) Notice of any known revocation of a POLST;

(b) Prescribe the manner for submitting information described in paragraph (a) of this subsection;

(c) Require the release of registry information to authorized users for treatment purposes;

(d) Authorize notification by the registry to specified persons of the receipt, revision or revocation of a POLST; and

(e) Establish procedures to protect the accuracy and confidentiality of information submitted to the registry.

(3) The authority may permit qualified researchers to access registry data. If the authority permits qualified researchers to have access to registry data, the authority shall adopt rules governing the access to data that shall include but need not be limited to:

(a) The process for a qualified researcher to request access to registry data;

(b) The types of data that a qualified researcher may be provided from the registry; and

(c) The manner by which a researcher must protect registry data obtained under this subsection.

(4) The authority may contract with a private or public entity to establish or maintain the registry, and such contract is exempt from the requirements of ORS chapters 279A, 279B and 279C.

SECTION 40. Nothing in sections 37 to 44 of this 2009 Act requires the Oregon Health Authority to:

(1) Prescribe the form or content of a POLST;

(2) Disseminate forms to be used for a POLST;

(3) Educate the public about POLSTs generally; or

(4) Train health care providers about POLSTs.

SECTION 41. (1) There is established the Oregon POLST Registry Advisory Committee to advise the Oregon Health Authority regarding the implementation, operation and evaluation of the POLST registry.

(2) The members of the Oregon POLST Registry Advisory Committee shall be appointed by the Director of the Oregon Health Authority and shall include, at a minimum:

(a) A health professional with extensive experience and leadership in POLST issues;

(b) A physician who is a supervising physician, as defined in ORS 682.025, for emergency medical technicians and who has extensive experience and leadership in POLST issues;

(c) A representative from the hospital community with extensive experience and leadership in POLST issues;

(d) A representative from the long term care community with extensive experience and leadership in POLST issues;

(e) A representative from the hospice community with extensive experience and leadership in POLST issues;

(f) An emergency medical technician actively involved in providing emergency medical services; and

(g) Two members of the public with active interest in end-of-life treatment preferences, at least one of whom represents the interests of minorities.

(3) The Director of the Emergency Medical Services and Trauma Systems Program within the Department of Human Services, or a designee of the director, shall serve as a voting ex officio member of the committee.

(4) The Director of the Oregon Health Authority may appoint additional members to the committee.

(5) The committee shall meet at least four times per year, at times and places specified by the Director of the Oregon Health Authority.

(6) The authority shall provide staff support for the committee.

(7) Except for the Director of the Emergency Medical Services and Trauma Systems

Program, a member of the committee shall serve a term of two years. Before the expiration of the term of a member, the director shall appoint a successor whose term begins on January 2 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Director of the Oregon Health Authority shall make an appointment to become immediately effective for the unexpired term.

(8) The Director of the Oregon Health Authority, or a designee of the director, shall consult with the committee in drafting rules on the implementation, operation and evaluation of the POLST registry.

SECTION 42. Notwithstanding the term of office specified in section 41 of this 2009 Act, of the members described in section 41 (2) of this 2009 Act who are first appointed to the Oregon POLST Registry Advisory Committee:

(1) At least two shall serve for terms ending January 1, 2011.

(2) At least three shall serve for terms ending January 1, 2012.

(3) At least three shall serve for terms ending January 1, 2013.

SECTION 43. Except as provided in section 39 of this 2009 Act, all information collected or developed by the POLST registry that identifies or could be used to identify a patient, health care provider or facility is confidential and is not subject to civil or administrative subpoena or to discovery in a civil action, including but not limited to a judicial, administrative, arbitration or mediation proceeding.

SECTION 44. Any person reporting information to the POLST registry or acting on information obtained from the POLST registry in good faith is immune from any civil or criminal liability that might otherwise be incurred or imposed with respect to the reporting of information to the POLST registry or acting on information obtained from the POLST registry.

SECTION 45. ORS 163.206 is amended to read:

163.206. ORS 163.200 and 163.205 do not apply:

(1) To a person acting pursuant to a court order, an advance directive**,** [*or*] a power of attorney for health care pursuant to ORS 127.505 to 127.660 **or a POLST, as defined in section 37 of this 2009 Act**;

(2) To a person withholding or withdrawing life-sustaining procedures or artificially administered nutrition and hydration pursuant to ORS 127.505 to 127.660;

(3) When a competent person refuses food, physical care or medical care;

(4) To a person who provides an elderly person or a dependent person who is at least 15 years of age with spiritual treatment through prayer from a duly accredited practitioner of spiritual treatment as provided in ORS 124.095, in lieu of medical treatment, in accordance with the tenets and practices of a recognized church or religious denomination of which the elderly or dependent person is a member or an adherent; or

(5) To a duly accredited practitioner of spiritual treatment as provided in ORS 124.095.

NO RESTRAINT OF TRADE

SECTION 46. The Legislative Assembly declares that collaboration among public payers, health insurance carriers, third-party purchasers and health care providers to identify appropriate reimbursement methods to align incentives in support of patient-centered primary care homes is in the best interests of the public. The Legislative Assembly therefore declares

its intent to exempt from state antitrust laws and to provide immunity from federal antitrust laws, the learning collaborative and other payment reforms designed and implemented pursuant to section 9 of this 2009 Act. The Legislative Assembly does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state or federal antitrust laws, including but not limited to agreements among competing health care providers or health carriers as to the prices or reimbursement levels for health care services.

TRANSFER OF DUTIES, FUNCTIONS AND POWERS

(Duties, Functions and Powers)

SECTION 47. (1) All of the duties, functions and powers of the Department of Human Services, the Office of Private Health Partnerships, the Oregon Educators Benefit Board and the Public Employees' Benefit Board with respect to duties enumerated in section 24 of this 2009 Act are transferred to and vested in the Oregon Health Authority.

(2) The Oregon Health Policy Commission is abolished. The tenure of office of the members of the Oregon Health Policy Commission ceases. All the duties, functions and powers of the Oregon Health Policy Commission are imposed upon, transferred to and vested in the Oregon Health Authority.

(3) The Oregon Health Fund Board is abolished. The tenure of office of the members of the Oregon Health Fund Board ceases. All the duties, functions and powers of the Oregon Health Fund Board are imposed upon, transferred to and vested in the Oregon Health Authority.

(Records, Property and Employees)

SECTION 48. (1) The executive director of the Oregon Health Fund Board shall:

(a) Deliver to the Oregon Health Authority all records and property within the jurisdiction of the executive director that relate to the duties, functions and powers transferred by section 47 of this 2009 Act; and

(b) Transfer to the authority those employees engaged primarily in the exercise of the duties, functions and powers transferred by section 47 of this 2009 Act.

(2) The Director of the Oregon Health Authority shall take possession of the records and property, and shall take charge of the employees and employ them in the exercise of the duties, functions and powers transferred by section 47 of this 2009 Act, without reduction of compensation but subject to change or termination of employment or compensation as provided by law.

(3) The Governor shall resolve any dispute between the Oregon Health Fund Board and the Oregon Health Authority relating to transfers of records, property and employees under this section, and the Governor's decision is final.

(Unexpended Balances)

SECTION 49. (1) On the effective date of this 2009 Act, the unexpended balances in the

Oregon Health Fund established by section 8, chapter 697, Oregon Laws 2007, are transferred to Oregon Health Authority Fund and are available for expenditure by the Oregon Health Authority for the biennium beginning July 1, 2007, for the purposes of administering and enforcing the duties, functions and powers transferred by section 47 of this 2009 Act.

(2) The expenditure classifications, if any, established by Acts authorizing or limiting expenditures by the Oregon Health Fund Board remain applicable to expenditures by the authority under this section.

(Effect on Actions, Proceedings and Prosecutions)

SECTION 50. The transfer of duties, functions and powers to the Oregon Health Authority by section 47 of this 2009 Act does not affect any action, proceeding or prosecution involving or with respect to such duties, functions and powers begun before and pending at the time of the transfer, except that the Oregon Health Authority is substituted for Oregon Health Fund Board in the action, proceeding or prosecution.

(Effect on Liabilities, Duties and Obligations)

SECTION 51. (1) Nothing in sections 47 to 50 of this 2009 Act relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions and powers transferred by section 47 of this 2009 Act. The Oregon Health Authority may undertake the collection or enforcement of any such liability, duty or obligation.

(2) The rights and obligations of the Oregon Health Fund Board legally incurred under contracts, leases and business transactions executed, entered into or begun before the effective date of section 47 of this 2009 Act and with respect to the duties, functions and powers transferred by section 47 of this 2009 Act are transferred to the Oregon Health Authority. For the purpose of succession to these rights and obligations, the Oregon Health Authority is a continuation of the Oregon Health Fund Board and not a new authority.

THIRD PARTY ADMINISTRATORS

SECTION 52. 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.

PREMIUM RATE FILING

SECTION 52a. Sections 52b and 52c of this 2009 Act are added to and made a part of ORS chapter 743.

SECTION 52b. (1) When an insurer files a schedule or table of premium rates for individual portability or small employer health insurance under ORS 743.018, the Director of the Department of Consumer and Business Services shall open a 30-day public comment period on the rate filing that begins on the date the insurer files the schedule or table of premium rates. The director may not accept public comments that do not pertain to the rating standards and factors prescribed by the director under ORS 743.018 or to the statement of administrative expenses filed under section 52c of this 2009 Act. The director shall post all comments that are accepted to the website of the Department of Consumer and Business Services without delay.

(2) The director shall give written notice to an insurer approving or disapproving a rate filing or, with the written consent of the insurer, modifying a rate filing submitted under ORS 743.018 no later than 10 business days after the close of the public comment period. The notice shall comply with the requirements of ORS 183.415.

SECTION 52c. An insurer licensed by the Department of Consumer and Business Services shall include in any rate filing under ORS 743.018 with respect to individual and small group insurance policies a statement of administrative expenses in the form and manner prescribed by the department by rule. The statement must include, but is not limited to:

(1) A statement of administrative expenses on a per member per month basis; and

(2) An explanation of the basis for any proposed premium rate increases or decreases.

SECTION 52d. ORS 743.018 is amended to read:

743.018. (1) Except for group life and health insurance, and except as provided in ORS 743.015, every insurer shall file with the Director of the Department of Consumer and Business Services all schedules and tables of premium rates for life and health insurance to be used on risks in this state, and shall file any amendments to or corrections of such schedules and tables. **Premium rates are subject to approval, disapproval or withdrawal of approval by the director as provided in ORS 742.003, 742.005 and 742.007.**

(2) Except as provided in ORS 743.737 and 743.760 and subsection (3) of this section, a rate filing by a carrier for any of the following health benefit plans subject to ORS 743.730 to 743.773 shall be available for public inspection immediately upon submission of the filing to the director:

(a) Health benefit plans for small employers.

(b) Portability health benefit plans.

(c) Individual health benefit plans.

(3) The director, upon request by a carrier, may exempt from disclosure any part of the filing that the director determines to contain trade secrets and that would, if disclosed, harm competition. The part that the director determines to be exempt from disclosure shall be considered confidential for purposes of ORS 705.137. The director may not disclose a part of a filing subject to a carrier's request pending the director's determination under this subsection.

(4) The director may by rule:

(a) Specify all information a carrier must submit as part of a rate filing under this section; and

(b) Identify the information submitted that will be exempt from disclosure under this

section because the information constitutes a trade secret and would, if disclosed, harm competition.

(5) The director, after conducting an actuarial review of the rate filing, may approve a proposed premium rate for a health benefit plan for small employers or for an individual health benefit plan if, in the director's discretion, the proposed rates are:

(a) Actuarially sound;

(b) Reasonable and not excessive, inadequate or unfairly discriminatory; and

(c) Based upon reasonable administrative expenses.

(6) In order to determine whether the proposed premium rates for a health benefit plan for small employers or for an individual health benefit plan are reasonable and not excessive, inadequate or unfairly discriminatory, the director may consider:

(a) The insurer's financial position, including but not limited to profitability, surplus, reserves and investment savings.

(b) Historical and projected administrative costs and medical and hospital expenses.

(c) Historical and projected loss ratio between the amounts spent on medical services and earned premiums.

(d) Any anticipated change in the number of enrollees if the proposed premium rate is approved.

(e) Changes to covered benefits or health benefit plan design.

(f) Changes in the insurer's health care cost containment and quality improvement efforts since the insurer's last rate filing for the same category of health benefit plan.

(g) Whether the proposed change in the premium rate is necessary to maintain the insurer's solvency or to maintain rate stability and prevent excessive rate increases in the future.

(h) An actuarially sound allowance that may not be less than zero for a contribution to surplus, contingency charge or risk charge justified by a recognition of the insurer's investment earnings on assets other than those related to claim reserves or other similar liabilities.

(i) Any public comments accepted under section 52b of this 2009 Act.

(7) With the written consent of the insurer, the director may modify a schedule or table of premium rates filed in accordance with subsection (1) of this section.

(8) The requirements of this section may not supersede other provisions of law that require insurers, health care service contractors or multiple employer welfare arrangements providing health insurance to file schedules or tables of premium rates or proposed premium rates with the director or to seek the director's approval of rates or changes to rates.

CONFORMING AMENDMENTS

SECTION 53. ORS 65.800 is amended to read:

65.800. For purposes of ORS 65.803 to 65.815:

(1) "Hospital" [*means a hospital as defined*] **has the meaning given that term** in ORS 442.015 [*(19)*].

(2) "Noncharitable entity" means any person or entity that is not a public benefit or religious corporation and is not wholly owned or controlled by one or more public benefit or religious corporations.

SECTION 54. ORS 127.646 is amended to read:

127.646. As used in ORS 127.646 to 127.654:

(1) "Health care organization" means a home health agency, hospice program, hospital, long term care facility or health maintenance organization.

(2) "Health maintenance organization" has the meaning given that term in ORS 750.005, except that "health maintenance organization" includes only those organizations that participate in the federal Medicare or Medicaid programs.

(3) "Home health agency" has the meaning given that term in ORS 443.005.

(4) "Hospice program" has the meaning given that term in ORS 443.850.

(5) "Hospital" has the meaning given that term in ORS 442.015 [*(19)*], except that "hospital" does not include a special inpatient care facility.

(6) "Long term care facility" has the meaning given that term in ORS 442.015, except that "long term care facility" does not include an intermediate care facility for individuals with mental retardation.

SECTION 55. ORS 243.061 is amended to read:

243.061. (1) There is created in the Oregon [*Department of Administrative Services*] **Health Authority** the Public Employees' Benefit Board consisting of eight voting members and two members of the Legislative Assembly as nonvoting advisory members. Two of the voting members are ex officio members and six are appointed by the Governor. The voting members shall be:

(a) Four members representing the state as an employer and management employees, who shall be as follows:

(A) The Director of the Oregon [*Department of Administrative Services*] **Health Authority** or a designee of the director;

(B) The Administrator of the Office for Oregon Health Policy and Research or a designee of the administrator; and

(C) Two management employees appointed by the Governor from areas of state government other than the Oregon Department of Administrative Services or the Office for Oregon Health Policy and Research; and

(b) Four members appointed by the Governor and representing nonmanagement representable employees, who shall be as follows:

(A) Two persons from the largest employee representative unit;

(B) One person from the second largest employee representative unit; and

(C) One person from representable employees not represented by employee representative units described in subparagraphs (A) and (B) of this paragraph.

(2) One member of the Senate shall be appointed by the President of the Senate and one member of the House of Representatives shall be appointed by the Speaker of the House to serve as nonvoting advisory members.

(3) The term of office of each appointed voting member is four years, but an appointed voting member serves at the pleasure of the Governor. Before the expiration of the term of a voting member appointed by the Governor, the Governor shall appoint a successor to take office upon the date of that expiration. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(4) The appointments by the Governor of voting members of the board are subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

(5) Members of the board who are not members of the Legislative Assembly shall receive no

compensation for their services, but shall be paid for their necessary and actual expenses while on official business in accordance with ORS 292.495. Members of the board who are members of the Legislative Assembly shall be paid compensation and expense reimbursement as provided in ORS 171.072, payable from funds appropriated to the Legislative Assembly.

SECTION 56. ORS 243.862 is amended to read:

243.862. (1) There is established in the Oregon [*Department of Administrative Services*] **Health Authority** an Oregon Educators Benefit Board consisting of 10 members appointed by the Governor, including:

(a) Two members representing district boards;

(b) Two members representing district management;

(c) Two members representing nonmanagement district employees from the largest labor organization representing district employees;

(d) One member representing nonmanagement district employees from the second largest labor organization representing district employees;

(e) One member representing nonmanagement district employees who are not represented by labor organizations described in paragraphs (c) and (d) of this subsection; and

(f) Two members with expertise in health policy or risk management.

(2) The term of office of each member is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor to take office upon the date of that expiration. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(3) A member of the board is not entitled to compensation, but may be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by the member in the performance of the member's official duties in the manner and amount provided in ORS 292.495.

(4) The board 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 such offices as the board determines.

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

(6) The board shall meet at times and places specified by the call of the chairperson or of a majority of the members of the board.

(7) Appointments of members to the board by the Governor are subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

SECTION 57. ORS 244.050 is amended to read:

244.050. (1) On or before April 15 of each year the following persons shall file with the Oregon Government Ethics Commission a verified statement of economic interest as required under this chapter:

(a) The Governor, Secretary of State, State Treasurer, Attorney General, Commissioner of the Bureau of Labor and Industries, Superintendent of Public Instruction, district attorneys and members of the Legislative Assembly.

(b) Any judicial officer, including justices of the peace and municipal judges, except any pro tem judicial officer who does not otherwise serve as a judicial officer.

(c) Any candidate for a public office designated in paragraph (a) or (b) of this subsection.

(d) The Deputy Attorney General.

(e) The Legislative Administrator, the Legislative Counsel, the Legislative Fiscal Officer, the Secretary of the Senate and the Chief Clerk of the House of Representatives.

(f) The Chancellor and Vice Chancellors of the Oregon University System and the president and vice presidents, or their administrative equivalents, in each institution under the jurisdiction of the State Board of Higher Education.

(g) The following state officers:

(A) Adjutant General.

(B) Director of Agriculture.

(C) Manager of State Accident Insurance Fund Corporation.

(D) Water Resources Director.

(E) Director of Department of Environmental Quality.

(F) Director of Oregon Department of Administrative Services.

(G) State Fish and Wildlife Director.

(H) State Forester.

(I) State Geologist.

(J) Director of Human Services.

(K) Director of the Department of Consumer and Business Services.

(L) Director of the Department of State Lands.

(M) State Librarian.

(N) Administrator of Oregon Liquor Control Commission.

(O) Superintendent of State Police.

(P) Director of the Public Employees Retirement System.

(Q) Director of Department of Revenue.

(R) Director of Transportation.

(S) Public Utility Commissioner.

(T) Director of Veterans' Affairs.

(U) Executive Director of Oregon Government Ethics Commission.

(V) Director of the State Department of Energy.

(W) Director and each assistant director of the Oregon State Lottery.

(h) Any assistant in the Governor's office other than personal secretaries and clerical personnel.

(i) Every elected city or county official.

(j) Every member of a city or county planning, zoning or development commission.

(k) The chief executive officer of a city or county who performs the duties of manager or principal administrator of the city or county.

(L) Members of local government boundary commissions formed under ORS 199.410 to 199.519.

(m) Every member of a governing body of a metropolitan service district and the executive officer thereof.

(n) Each member of the board of directors of the State Accident Insurance Fund Corporation.

(o) The chief administrative officer and the financial officer of each common and union high school district, education service district and community college district.

(p) Every member of the following state boards and commissions:

(A) Board of Geologic and Mineral Industries.

(B) Oregon Economic and Community Development Commission.

(C) State Board of Education.

(D) Environmental Quality Commission.

(E) Fish and Wildlife Commission of the State of Oregon.

(F) State Board of Forestry.

(G) Oregon Government Ethics Commission.

(H) Oregon Health [*Policy Commission*] **Authority Board**.

(I) State Board of Higher Education.

(J) Oregon Investment Council.

(K) Land Conservation and Development Commission.

(L) Oregon Liquor Control Commission.

(M) Oregon Short Term Fund Board.

(N) State Marine Board.

(O) Mass transit district boards.

(P) Energy Facility Siting Council.

(Q) Board of Commissioners of the Port of Portland.

(R) Employment Relations Board.

(S) Public Employees Retirement Board.

(T) Oregon Racing Commission.

(U) Oregon Transportation Commission.

(V) Wage and Hour Commission.

(W) Water Resources Commission.

(X) Workers' Compensation Board.

(Y) Oregon Facilities Authority.

(Z) Oregon State Lottery Commission.

(AA) Pacific Northwest Electric Power and Conservation Planning Council.

(BB) Columbia River Gorge Commission.

(CC) Oregon Health and Science University Board of Directors.

(q) The following officers of the State Treasurer:

(A) Chief Deputy State Treasurer.

(B) Chief of staff for the office of the State Treasurer.

(C) Director of the Investment Division.

(r) Every member of the board of commissioners of a port governed by ORS 777.005 to 777.725 or 777.915 to 777.953.

(s) Every member of the board of directors of an authority created under ORS 441.525 to 441.595.

(2) By April 15 next after the date an appointment takes effect, every appointed public official on a board or commission listed in subsection (1) of this section shall file with the Oregon Government Ethics Commission a statement of economic interest as required under ORS 244.060, 244.070 and 244.090.

(3) By April 15 next after the filing deadline for the primary election, each candidate for public office described in subsection (1) of this section shall file with the commission a statement of economic interest as required under ORS 244.060, 244.070 and 244.090.

(4) Within 30 days after the filing deadline for the general election, each candidate for public office described in subsection (1) of this section who was not a candidate in the preceding primary election, or who was nominated for public office described in subsection (1) of this section at the preceding primary election by write-in votes, shall file with the commission a statement of economic interest as required under ORS 244.060, 244.070 and 244.090.

(5) Subsections (1) to (4) of this section apply only to persons who are incumbent, elected or

appointed public officials as of April 15 and to persons who are candidates for public office on April 15. Subsections (1) to (4) of this section also apply to persons who do not become candidates until 30 days after the filing deadline for the statewide general election.

(6) If a statement required to be filed under this section has not been received by the commission within five days after the date the statement is due, the commission shall notify the public official or candidate and give the public official or candidate not less than 15 days to comply with the requirements of this section. If the public official or candidate fails to comply by the date set by the commission, the commission may impose a civil penalty as provided in ORS 244.350.

SECTION 58. ORS 409.720 is amended to read:

409.720. (1) As used in this section:

(a) "Adult foster home" has the meaning given that term in ORS 443.705 (1).

(b) "Health care facility" has the meaning given that term in ORS 442.015 [*(16)*].

(c) "Residential facility" has the meaning given that term in ORS 443.400 (6).

(2) Every adult foster home, health care facility and residential facility licensed or registered by the Department of Human Services shall:

(a) Adopt a plan to provide for the safety of persons who are receiving care at or are residents of the home or facility in the event of an emergency that requires immediate action by the staff of the home or facility due to conditions of imminent danger that pose a threat to the life, health or safety of persons who are receiving care at or are residents of the home or facility; and

(b) Provide training to all employees of the home or facility about the responsibilities of the employees to implement the plan required by this section.

(3) The department shall adopt by rule the requirements for the plan and training required by this section. The rules adopted shall include, but are not limited to, procedures for the evacuation of the persons who are receiving care at or are residents of the adult foster home, health care facility or residential facility to a place of safety when the conditions of imminent danger require relocation of those persons.

SECTION 59. ORS 414.021 is amended to read:

414.021. (1) The Administrator of the Office for Oregon Health Policy and Research shall be responsible for analyzing and reporting on the implementation of the elements of the Oregon Health Plan that are assigned to various state agencies, including but not limited to the Department of Human Services and the Department of Consumer and Business Services.

(2) The administrator shall administer the Health Services Commission, the Medicaid Advisory Committee and the Health Resources Commission [*and provide administrative support to the Oregon Health Policy Commission*]. Pursuant to the responsibilities described in this subsection and subsection (1) of this section, the administrator may review and monitor the progress of the various activities that comprise Oregon's efforts to reform health care through state-funded and employer-based coverage. Except for administration of the Health Services Commission, the Medicaid Advisory Committee and the Health Resources Commission [*and providing administrative support to the Oregon Health Policy Commission*] and as specifically authorized in ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712, the administrator shall not be responsible for the day-to-day operations of the Oregon Health Plan, but shall exercise such oversight responsibilities as are necessary to further the Oregon Health Plan's goals.

(3) The administrator shall employ such staff or utilize such state agency personnel as are necessary to fulfill the responsibilities and duties of the administrator. In addition, the administrator may contract with third parties for technical and administrative services necessary to carry out

Oregon Health Plan activities where contracting promotes economy, avoids duplication of effort and makes best use of available expertise. The administrator may call upon other state agencies to provide available information as necessary to assist the administrator in meeting the responsibilities under ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712. The information shall be supplied as promptly as circumstances permit.

[*(4) The Oregon Health Policy Commission shall serve as the primary advisory committee to the administrator, the Governor and the Legislative Assembly. The administrator also may appoint other technical or advisory committees to assist the Oregon Health Policy Commission in formulating its advice. Individuals appointed to any technical or other advisory committee shall serve without compensation for their services as members, but may be reimbursed for their travel expenses pursuant to ORS 292.495.*]

[*(5)*] **(4)** The administrator may apply for, receive and accept grants, gifts and other payments, including property and services, from any governmental or other public or private entity or person and may make arrangements for the use of these receipts, including the undertaking of special studies and other projects relating to health care costs and access to health care.

[*(6)*] **(5)** The directors of the Departments of Human Services and Consumer and Business Services and other state agency personnel responsible for implementing elements of the Oregon Health Plan shall cooperate fully with the administrator in carrying out their responsibilities under the Oregon Health Plan.

[*(7) All health policy advisory committees reporting to the Office for Oregon Health Policy and Research and all advisory task forces on health policy appointed by the administrator shall report directly to the Oregon Health Policy Commission.*]

[*(8)(a)*] **(6)(a)** ORS 192.610 to 192.690 apply to any meeting of any technical or advisory committee or advisory task force with the authority to make decisions for, conduct policy research for or make recommendations to the Office for Oregon Health Policy and Research.

(b) Paragraph (a) of this subsection applies only to meetings attended by two or more committee or task force members who are not employed by a public body.

SECTION 60. ORS 432.500 is amended to read:

432.500. As used in ORS 432.510 to 432.550 and 432.900:

(1) "Clinical laboratory" means a facility where microbiological, serological, chemical, hematological, immunohematological, immunological, toxicological, cytogenetical, exfoliative cytological, histological, pathological or other examinations are performed on material derived from the human body, for the purpose of diagnosis, prevention of disease or treatment of patients by physicians, dentists and other persons who are authorized by license to diagnose or treat humans.

(2) "Department" means the Department of Human Services or its authorized representative.

(3) "Health care facility" means a hospital, as defined in ORS 442.015 [*(19)*], or an ambulatory surgical center, as defined in ORS 442.015.

(4) "Practitioner" means any person whose professional license allows the person to diagnose or treat cancer in patients.

SECTION 61. ORS 442.011 is amended to read:

442.011. [*(1)*] There is created in the Department of Human Services the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal

aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

[*(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission and the Oregon Health Fund Board.*]

SECTION 62. ORS 442.011, as amended by section 15, chapter 697, Oregon Laws 2007, is amended to read:

442.011. [*(1)*] There is created in the Department of Human Services the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

[*(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission.*]

SECTION 63. ORS 442.015 is amended to read:

442.015. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, with intention of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

(2) "Adjusted admission" means the sum of all inpatient admissions divided by the ratio of inpatient revenues to total patient revenues.

(3) "Affected persons" has the same meaning as given to "party" in ORS 183.310.

(4) "Ambulatory surgical center" means a facility that performs outpatient surgery not routinely or customarily performed in a physician's or dentist's office, and is able to meet health facility licensure requirements.

(5) "Audited actual experience" means data contained within financial statements examined by an independent, certified public accountant in accordance with generally accepted auditing standards.

(6) "Budget" means the projections by the hospital for a specified future time period of expenditures and revenues with supporting statistical indicators.

(7) "Case mix" means a calculated index for each hospital, based on financial accounting and case mix data collection as set forth in ORS 442.425, reflecting the relative costliness of that hospital's mix of cases compared to a state or national mix of cases.

[*(8) "Commission" means the Oregon Health Policy Commission.*]

[*(9) "Department" means the Department of Human Services of the State of Oregon.*]

[*(10)*] **(8)** "Develop" means to undertake those activities that on their completion will result in

the offer of a new institutional health service or the incurring of a financial obligation, as defined under applicable state law, in relation to the offering of such a health service.

[*(11)*] **(9)** "Director" means the Director of Human Services.

[*(12)*] **(10)** "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a donation or grant in lieu of an expenditure but not including any interest thereon.

[*(13)*] **(11)** "Freestanding birthing center" means a facility licensed for the primary purpose of performing low risk deliveries.

[*(14)*] **(12)** "Governmental unit" means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

[*(15)*] **(13)** "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. "Gross revenue" does not include contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

[*(16)(a)*] **(14)(a)** "Health care facility" means a hospital, a long term care facility, an ambulatory surgical center, a freestanding birthing center or an outpatient renal dialysis facility.

(b) "Health care facility" does not mean:

(A) An establishment furnishing residential care or treatment not meeting federal intermediate care standards, not following a primarily medical model of treatment, prohibited from admitting persons requiring 24-hour nursing care and licensed or approved under the rules of the Department of Human Services or the Department of Corrections; or

(B) An establishment furnishing primarily domiciliary care.

[*(17)*] **(15)** "Health maintenance organization" or "HMO" means a public organization or a private organization organized under the laws of any state that:

(a) Is a qualified HMO under section 1310 (d) of the U.S. Public Health Services Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

[*(18)*] **(16)** "Health services" means clinically related diagnostic, treatment or rehabilitative services, and includes alcohol, drug or controlled substance abuse and mental health services that may be provided either directly or indirectly on an inpatient or ambulatory patient basis.

[*(19)*] **(17)** "Hospital" means a facility with an organized medical staff, with permanent facilities that include inpatient beds and with medical services, including physician services and continuous nursing services under the supervision of registered nurses, to provide diagnosis and medical or surgical treatment primarily for but not limited to acutely ill patients and accident victims, to pro-

vide treatment for patients with mental illness or to provide treatment in special inpatient care facilities.

[*(20)*] **(18)** "Institutional health services" means health services provided in or through health care facilities and includes the entities in or through which such services are provided.

[*(21)*] **(19)** "Intermediate care facility" means a facility that provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

[*(22)*] **(20)** "Long term care facility" means a facility with permanent facilities that include inpatient beds, providing medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the director, to provide treatment for two or more unrelated patients. "Long term care facility" includes skilled nursing facilities and intermediate care facilities but may not be construed to include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

[*(23)*] **(21)** "Major medical equipment" means medical equipment that is used to provide medical and other health services and that costs more than $1 million. "Major medical equipment" does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services, if the clinical laboratory is independent of a physician's office and a hospital and has been determined under Title XVIII of the Social Security Act to meet the requirements of paragraphs (10) and (11) of section 1861(s) of that Act.

[*(24)*] **(22)** "Net revenue" means gross revenue minus deductions from revenue.

[*(25)*] **(23)** "New hospital" means a facility that did not offer hospital services on a regular basis within its service area within the prior 12-month period and is initiating or proposing to initiate such services. "New hospital" also includes any replacement of an existing hospital that involves a substantial increase or change in the services offered.

[*(26)*] **(24)** "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. "New skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period.

[*(27)*] **(25)** "Offer" means that the health care facility holds itself out as capable of providing, or as having the means for the provision of, specified health services.

[*(28)*] **(26)** "Operating expenses" means the sum of daily hospital service expenses, ambulatory service expenses, ancillary expenses and other operating expenses, excluding income taxes.

[*(29)*] **(27)** "Outpatient renal dialysis facility" means a facility that provides renal dialysis services directly to outpatients.

[*(30)*] **(28)** "Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation, of a state.

[*(31)*] **(29)** "Skilled nursing facility" means a facility or a distinct part of a facility, that is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or an institution that provides rehabilitation services for the re-

habilitation of individuals who are injured or sick or who have disabilities.

[*(32)*] **(30)** "Special inpatient care facility" means a facility with permanent inpatient beds and other facilities designed and utilized for special health care purposes, including but not limited to a rehabilitation center, a college infirmary, a chiropractic facility, a facility for the treatment of alcoholism or drug abuse, an inpatient care facility meeting the requirements of ORS 441.065, and any other establishment falling within a classification established by the Department of Human Services, after determination of the need for such classification and the level and kind of health care appropriate for such classification.

[*(33)*] **(31)** "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts, contractual adjustments, uncompensated care, administrative, courtesy and policy discounts and adjustments and other such revenue deductions. The deduction shall be net of the offset of restricted donations and grants for indigent care.

SECTION 64. ORS 442.700 is amended to read:

442.700. As used in ORS 442.700 to 442.760:

(1) "Board of governors" means the governors of a cooperative program as described in ORS 442.720.

(2) "Cooperative program" means a program among two or more health care providers for the purpose of providing heart and kidney transplant services including, but not limited to, the sharing, allocation and referral of physicians, patients, personnel, instructional programs, support services, facilities, medical, diagnostic, laboratory or therapeutic services, equipment, devices or supplies, and other services traditionally offered by health care providers.

(3) "Director" means the Director of Human Services.

(4) "Health care provider" means a hospital, physician or entity, a significant part of whose activities consist of providing hospital or physician services in this state. For purposes of the immunities provided by ORS 442.700 to 442.760 and 646.740, "health care provider" includes any officer, director, trustee, employee, or agent of, or any entity under common ownership and control with, a health care provider.

(5) "Hospital" means a hospital, as defined in ORS 442.015 [*(19)*], or a long term care facility or an ambulatory surgical center, as those terms are defined in ORS 442.015, that is licensed under ORS 441.015 to 441.089. "Hospital" includes community health programs established under ORS 430.610 to 430.695.

(6) "Order" means a decision issued by the director under ORS 442.710 either approving or denying an application for a cooperative program and includes modifications of an original order under ORS 442.730 (3)(b) and ORS 442.740 (1) and (4).

(7) "Party to a cooperative program agreement" or "party" means an entity that enters into the principal agreement to establish a cooperative program and applies for approval under ORS 442.700 to 442.760 and 646.740 and any other entity that, with the approval of the director, becomes a member of a cooperative program.

(8) "Physician" means a physician defined in ORS 677.010 (13) and licensed under ORS chapter 677.

SECTION 65. ORS 678.730 is amended to read:

678.730. (1) Any individual is qualified for licensure as a nursing home administrator who:

(a) Meets the training or experience and other standards established by rules of the Board of Examiners of Nursing Home Administrators. The board shall accept one year of experience as an

administrator serving a dual facility in lieu of any residency or intern requirement established pursuant to this paragraph; and

(b) Has passed an examination as provided in ORS 678.740.

(2) Each license as a nursing home administrator may be renewed by the board upon compliance by the licensee with the requirements of ORS 678.760 and by presenting evidence of the completion of the continuing education work required by the board. The board may require up to 50 hours of continuing education in any one-year period.

(3) In establishing educational standards pursuant to subsection (1)(a) of this section, the board shall require a baccalaureate degree from an accredited school of higher education. However, the educational requirement does not apply to any person who:

(a) Was a licensed administrator in any jurisdiction of the United States prior to January 1, 1983; or

(b) Was an administrator of a dual facility meeting the experience requirements pursuant to subsection (1)(a) of this section.

(4) Notwithstanding the requirements established under subsection (1) of this section, upon the request of the governing body of a hospital, as defined in ORS 442.015 [*(19)*], the board shall deem a health care administrator to have met the requirements for licensure as a nursing home administrator if the health care administrator possesses an advanced degree in management and has at least 10 years of experience in health care management.

SECTION 66. ORS 735.701 is amended to read:

735.701. (1) The Office of Private Health Partnerships is established **in the Oregon Health Authority**.

(2) The office shall carry out the duties described under ORS 414.831, 735.700 to 735.714 and 735.720 to 735.740.

SECTION 67. ORS 735.722 is amended to read:

735.722. (1) There is established the Family Health Insurance Assistance Program in the Office of Private Health Partnerships. The purpose of the program is to remove economic barriers to health insurance coverage for residents of the State of Oregon with family income less than 200 percent of the federal poverty level, and investment and savings less than the limit established by the office, while encouraging individual responsibility, promoting health benefit plan coverage of children, building on the private sector health benefit plan system and encouraging employer and employee participation in employer-sponsored health benefit plan coverage.

(2) The Office of Private Health Partnerships shall be responsible for the implementation and operation of the Family Health Insurance Assistance Program. The Administrator of the Office for Oregon Health Policy and Research[*, in consultation with the Oregon Health Policy Commission,*] shall make recommendations to the Office of Private Health Partnerships regarding program policy, including but not limited to eligibility requirements, assistance levels, benefit criteria and carrier participation.

(3) The Office of Private Health Partnerships may contract with one or more third-party administrators to administer one or more components of the Family Health Insurance Assistance Program. Duties of a third-party administrator may include but are not limited to:

(a) Eligibility determination;

(b) Data collection;

(c) Assistance payments;

(d) Financial tracking and reporting; and

(e) Such other services as the office may deem necessary for the administration of the program.

(4) If the office decides to enter into a contract with a third-party administrator pursuant to subsection (3) of this section, the office shall engage in competitive bidding. The office shall evaluate bids according to criteria established by the office, including but not limited to:

(a) The bidder's proven ability to administer a program of the size of the Family Health Insurance Assistance Program;

(b) The efficiency of the bidder's payment procedures;

(c) The estimate provided of the total charges necessary to administer the program; and

(d) The bidder's ability to operate the program in a cost-effective manner.

SECTION 68. ORS 743.730 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 conditions provision;

(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 for small employers that is required to be offered by all small employer carriers and approved by the Director of the Department of Consumer and Business Services in accordance with ORS 743.736.*]

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

[*(6)*] **(5)** "Carrier" means any person who provides health benefit plans in this state, including a licensed insurance company, a health care service contractor, a health maintenance organization, an association or group of employers that provides benefits by means of a multiple employer welfare arrangement or any other person or corporation responsible for the payment of benefits or provision of services.

[*(7)*] **(6)** "Committee" means the Health Insurance Reform Advisory Committee created under ORS 743.745.

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

[*(9)*] **(8)** "Department" means the Department of Consumer and Business Services.

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

[*(11)*] **(10)** "Director" means the Director of the Department of Consumer and Business Services.

[*(12)*] **(11)** "Eligible employee" means an employee of a small employer 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 small employer for fewer than 90 days are not eligible employees unless the small employer so allows.

[*(13)*] **(12)** "Employee" means any individual employed by an employer.

[*(14)*] **(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.

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

[*(16)*] **(15)** "Financially impaired" means a member that is not insolvent and is:

(a) Considered by the Director of the Department of Consumer and Business Services 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)*] **(16)(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) Small employer group health benefit plans;

(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)*] **(17)** "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.

[*(19)(a)*] **(18)** "Health benefit plan" means any hospital expense, medical expense or hospital or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance policies, coverage of CHAMPUS services pursuant to contracts with the federal government, 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, long term care insurance, hospital indemnity only, short term health insurance policies (the duration of which does not exceed six months including renewals), student accident and health insurance policies, dental only, vision only, a policy of stop-loss coverage that meets the requirements of ORS 742.065, coverage issued as

a supplement to liability insurance, 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 that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

[*(20)*] **(19)** "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 developed by the Health Insurance Reform Advisory Committee.

[*(21)*] **(20)** "Implementation of chapter 836, Oregon Laws 1989" means that the Health Services Commission has prepared a priority list, the Legislative Assembly has enacted funding of the list and all necessary federal approval, including waivers, has been obtained.

[*(22)*] **(21)** "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)*] **(22)** "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

[*(24)*] **(23)** "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 July 1, 1997;

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

(c) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's 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 who 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, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days of applying for coverage in a group health benefit plan.

[*(25)*] **(24)** "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.

[*(26)*] **(25)** "Oregon Medical Insurance Pool" means the pool created under ORS 735.610.

[*(27)*] **(26)** "Preexisting conditions provision" 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) A preexisting conditions provision shall not be applied to a newborn child or adopted child who obtains coverage in accordance with ORS 743A.090.

[*(28)*] **(27)** "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.

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

[*(30)(a)*] **(29)(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 issued by a small employer carrier.

(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.

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

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

SECTION 69. ORS 743.731 is amended to read:

743.731. The purposes of ORS 743.730 to 743.773 are:

(1) To promote the availability of health insurance coverage to groups regardless of their enrollees' health status or claims experience;

(2) To prevent abusive rating practices;

(3) To require disclosure of rating practices to purchasers of small employer, portability and individual health benefit plans;

(4) To establish limitations on the use of preexisting conditions provisions;

(5) To make [*basic*] **standard value-based** health benefit plans available to all small employers;

(6) To encourage the availability of portability and individual health benefit plans for individuals who are not enrolled in group health benefit plans;

(7) To improve renewability and continuity of coverage for employers and covered individuals;

(8) To improve the efficiency and fairness of the health insurance marketplace; and

(9) To ensure that health insurance coverage in Oregon satisfies the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and that enforcement authority for those requirements is retained by the Director of the Department of Consumer and Business Services.

SECTION 70. ORS 743.734 is amended to read:

743.734. (1) Every group health benefit plan shall be subject to the provisions of ORS 743.733 to

743.737, if the plan provides health benefits covering one or more employees of a small employer and if any one of the following conditions is met:

(a) Any portion of the premium or benefits is paid by a small employer or any eligible employee is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the health benefit plan premium; or

(b) The health benefit plan is treated by the employer or any of the eligible employees as part of a plan or program for the purposes of section 106, section 125 or section 162 of the Internal Revenue Code of 1986, as amended.

(2) Except as provided in ORS 743.733 to 743.737, no law requiring the coverage or the offer of coverage of a health care service or benefit applies to [*the basic*] **standard value-based** health benefit plans offered or delivered to a small employer.

(3) Except as otherwise provided by law or ORS 743.733 to 743.737, no health benefit plan offered to a small employer shall:

(a) Inhibit a small employer carrier from contracting with providers or groups of providers with respect to health care services or benefits; or

(b) Impose any restriction on the ability of a small employer carrier to negotiate with providers regarding the level or method of reimbursing care or services provided under health benefit plans.

(4) Except to determine the application of a preexisting conditions provision for a late enrollee, a small employer carrier shall not use health statements when offering small employer health benefit plans and shall not use any other method to determine the actual or expected health status of eligible enrollees. Nothing in this subsection shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

(5) Except in the case of a late enrollee and as otherwise provided in this section, a small employer carrier shall not impose different terms or conditions on the coverage, premiums or contributions of any eligible employee in a small employer group that are based on the actual or expected health status of any eligible employee.

(6) A small employer carrier may provide different health benefit plans to different categories of employees of a small employer when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or their dependents. The categories must be based on bona fide employment-based classifications that are consistent with the employer's usual business practice. Except as provided in ORS 743.736 [*(10)*] **(8)**:

(a) When a small employer carrier offers coverage to a small employer with no more than 25 eligible employees, the small employer carrier shall offer coverage to all eligible employees of the small employer, without regard to the actual or expected health status of any eligible employee.

(b) When a small employer carrier offers coverage to a small employer with at least 26 but not more than 50 eligible employees, the small employer carrier may limit coverage to the categories of employees that the small employer has established as eligible for coverage, provided that the categories are based on bona fide employment-based classifications that are consistent with the employer's usual business practice.

(c) If the small employer elects to offer coverage to dependents of eligible employees, the small employer carrier shall offer coverage to all dependents of eligible employees, without regard to the actual or expected health status of any eligible dependent.

(7) A health benefit plan issued to a small employer group through an association health plan

is exempt from subsection (1) of this section. For purposes of this subsection, an association health plan is group health insurance described in ORS 743.522 (2) or a health benefit plan that:

(a) Is delivered or issued for delivery to:

(A) An association or trust established in this state, that meets applicable requirements of ORS 743.524 or 743.526, or to a multiple employer welfare arrangement located inside this state, subject to ORS 750.301 to 750.341; or

(B) An association or trust established in another state, that is approved by the director under ORS 731.486 (7), or a multiple employer welfare arrangement located in another state that complies with ORS 750.311; and

(b) Satisfies all of the following:

(A) The initial premium rate for the association health plan does not vary by more than 50 percent across the groups of small employers under the plan.

(B) The association policyholder does not discriminate in membership requirements based on actual or expected health status of individual enrollees or prospective enrollees, in accordance with ORS 743.752 (5).

(C) Small employer groups that have two or more eligible employees and that meet the membership requirements for the association are not excluded from the association health plan.

(D) Except as provided in subsection (8) of this section, the association health plan maintains a 95 percent retention rate.

(8)(a) The 95 percent retention rate in subsection (7) of this section does not include employer groups that:

(A) Go out of business, whether through merger, acquisition or any other reason;

(B) No longer meet eligibility requirements for membership in the association;

(C) No longer meet participation requirements for employers that are set forth in the plan documents; or

(D) Fail to pay premiums.

(b) An association health plan that fails to maintain the 95 percent retention rate during any year may have 12 months to correct the retention level before losing the exemption under subsection (7) of this section.

SECTION 71. ORS 743.734, as amended by section 9, chapter 752, Oregon Laws 2007, is amended to read:

743.734. (1) Every group health benefit plan shall be subject to the provisions of ORS 743.733 to 743.737, if the plan provides health benefits covering one or more employees of a small employer and if any one of the following conditions is met:

(a) Any portion of the premium or benefits is paid by a small employer or any eligible employee is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the health benefit plan premium; or

(b) The health benefit plan is treated by the employer or any of the eligible employees as part of a plan or program for the purposes of section 106, section 125 or section 162 of the Internal Revenue Code of 1986, as amended.

(2) Except as provided in ORS 743.733 to 743.737, no law requiring the coverage or the offer of coverage of a health care service or benefit applies to [*the basic*] **standard value-based** health benefit plans offered or delivered to a small employer.

(3) Except as otherwise provided by law or ORS 743.733 to 743.737, no health benefit plan offered to a small employer shall:

(a) Inhibit a small employer carrier from contracting with providers or groups of providers with respect to health care services or benefits; or

(b) Impose any restriction on the ability of a small employer carrier to negotiate with providers regarding the level or method of reimbursing care or services provided under health benefit plans.

(4) Except to determine the application of a preexisting conditions provision for a late enrollee, a small employer carrier shall not use health statements when offering small employer health benefit plans and shall not use any other method to determine the actual or expected health status of eligible enrollees. Nothing in this subsection shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

(5) Except in the case of a late enrollee and as otherwise provided in this section, a small employer carrier shall not impose different terms or conditions on the coverage, premiums or contributions of any eligible employee in a small employer group that are based on the actual or expected health status of any eligible employee.

(6) A small employer carrier may provide different health benefit plans to different categories of employees of a small employer when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or their dependents. The categories must be based on bona fide employment-based classifications that are consistent with the employer's usual business practice. Except as provided in ORS 743.736 [*(10)*] **(8)**:

(a) When a small employer carrier offers coverage to a small employer with no more than 25 eligible employees, the small employer carrier shall offer coverage to all eligible employees of the small employer, without regard to the actual or expected health status of any eligible employee.

(b) When a small employer carrier offers coverage to a small employer with at least 26 but not more than 50 eligible employees, the small employer carrier may limit coverage to the categories of employees that the small employer has established as eligible for coverage, provided that the categories are based on bona fide employment-based classifications that are consistent with the employer's usual business practice.

(c) If the small employer elects to offer coverage to dependents of eligible employees, the small employer carrier shall offer coverage to all dependents of eligible employees, without regard to the actual or expected health status of any eligible dependent.

SECTION 72. ORS 743.737 is amended to read:

743.737. [*Health benefit plans covering small employers shall be subject to the following provisions:*]

(1) A preexisting conditions provision in a small employer health benefit plan shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the enrollment date of an enrollee or late enrollee. As used in this section, the enrollment date of an enrollee shall be the earlier of the effective date of coverage or the first day of any required group eligibility waiting period and the enrollment date of a late enrollee shall be the effective date of coverage.

(2) A preexisting conditions provision in a small employer health benefit plan shall terminate its effect as follows:

(a) For an enrollee, not later than the first of the following dates:

(A) Six months following the enrollee's effective date of coverage; or

(B) Ten months following the start of any required group eligibility waiting period.

(b) For a late enrollee, not later than 12 months following the late enrollee's effective date of coverage.

(3) In applying a preexisting conditions provision to an enrollee or late enrollee, except as provided in this subsection, all small employer health benefit plans shall reduce the duration of the provision by an amount equal to the enrollee's or late enrollee's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the enrollment date in the new small employer health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period. This subsection does not preclude, within a small employer health benefit plan, application of:

(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

(b) An exclusion period for specified covered services, as established by the Health Insurance Reform Advisory Committee, applicable to all individuals enrolling for the first time in the small employer health benefit plan.

(4) Late enrollees may be excluded from coverage **by small employer health benefit plans** for up to 12 months or may be subjected to a preexisting conditions provision for up to 12 months. If both an exclusion from coverage period and a preexisting conditions provision are applicable to a late enrollee, the combined period shall not exceed 12 months.

(5) Each small employer health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder, small employer or contract holder except:

(a) For nonpayment of the required premiums by the policyholder, small employer or contract holder.

(b) For fraud or misrepresentation of the policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, the enrollees or their representatives.

(c) When the number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) For noncompliance with the small employer carrier's employer contribution requirements under the health benefit plan.

(e) When the carrier discontinues offering or renewing, or offering and renewing, all of its small employer health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

(A) Must give notice of the decision to the Director of the Department of Consumer and Business Services and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except as provided in subparagraph (C) of this paragraph, in a specified service area;

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area; and

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the small employer market in this state or in the specified service area.

(f) When the carrier discontinues offering and renewing a small employer health benefit plan in a specified service area within this state because of an inability to reach an agreement with the

health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice to the director and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing**,** to each small employer covered by the plan, all other small employer health benefit plans that the carrier offers in the specified service area. The carrier shall issue any such plans pursuant to the provisions of ORS 743.733 to 743.737. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) When the carrier discontinues offering or renewing, or offering and renewing, a health benefit plan for all small employers in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing**,** to each small employer covered by the plan, all health benefit plans that the carrier offers in the specified service area.

(B) Issue any such plans pursuant to the provisions of ORS 743.733 to 743.737.

(C) Offer the plans at least 90 days prior to discontinuation.

(D) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(h) When the director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

(i) When, in the case of a small employer health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

(j) When, in the case of a health benefit plan that is offered in the small employer market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(k) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide services to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

[*(L)*] **(6)** A small employer carrier may modify a small employer health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under [*paragraphs (e) and (g) of this*] subsection **(5)(e) and (g) of this section**.

[*(6)*] **(7)** Notwithstanding any provision of subsection (5) **or (6)** of this section to the contrary, any small employer [*carrier*] health benefit plan subject to the provisions of ORS 743.733 to 743.737 may be rescinded by a small employer carrier for fraud, material misrepresentation or concealment by a small employer and the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.

[*(7)*] **(8)** A small employer carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage. However, participation and contribution requirements shall be applied uniformly among all small employer groups with the same

number of eligible employees applying for coverage or receiving coverage from the small employer carrier. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing group health benefit plan, Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan.

[*(8)*] **(9)** Premium rates for small employer health benefit plans **require approval by the director under ORS 742.003 and** shall be subject to **section 52b of this 2009 Act and** the following provisions:

(a) Each small employer carrier issuing health benefit plans to small employers must file its geographic average rate for a rating period with the director at least once every 12 months.

(b)(A) The premium rates charged during a rating period for health benefit plans issued to small employers may not vary from the geographic average rate by more than 50 percent on or after January 1, 2008, except as provided in subparagraph (D) of this paragraph.

(B) The variations in premium rates described in subparagraph (A) of this paragraph shall be based solely on the factors specified in subparagraph (C) of this paragraph. A small employer carrier may elect which of the factors specified in subparagraph (C) of this paragraph apply to premium rates for small employers. The factors that are based on contributions or participation may vary with the size of the employer. All other factors must be applied in the same actuarially sound way to all small employers.

(C) The variations in premium rates described in subparagraph (A) of this paragraph may be based on one or more of the following factors:

(i) The ages of enrolled employees and their dependents;

(ii) The level at which the small employer contributes to the premiums payable for enrolled employees and their dependents;

(iii) The level at which eligible employees participate in the health benefit plan;

(iv) The level at which enrolled employees and their dependents engage in tobacco use;

(v) The level at which enrolled employees and their dependents engage in health promotion, disease prevention or wellness programs;

(vi) The period of time during which a small employer retains uninterrupted coverage in force with the same small employer carrier; and

(vii) Adjustments to reflect the provision of benefits not required to be covered by [*the basic*] **a standard value-based** health benefit plan and differences in family composition.

(D)(i) The premium rates determined in accordance with this paragraph may be further adjusted by a small employer carrier to reflect the expected claims experience of a small employer, but the extent of this adjustment may not exceed five percent of the annual premium rate otherwise payable by the small employer. The adjustment under this subparagraph may not be cumulative from year to year.

(ii) Except for small employers with 25 or fewer employees, the premium rates adjusted under this subparagraph are not subject to the provisions of subparagraph (A) of this paragraph.

(E) A small employer carrier shall apply the carrier's schedule of premium rate variations as approved by the director [*of the Department of Consumer and Business Services*] and in accordance with this paragraph. Except as otherwise provided in this section, the premium rate established for a health benefit plan by a small employer carrier shall apply uniformly to all employees of the small employer enrolled in that plan.

(c) Except as provided in paragraph (b) of this subsection, the variation in premium rates be-

tween different small employer health benefit plans offered by a small employer carrier must be based solely on objective differences in plan design or coverage and must not include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

(d) A small employer carrier may not increase the rates of a health benefit plan issued to a small employer more than once in a 12-month period. Annual rate increases shall be effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the geographic average rate measured from the first day of the prior rating period to the first day of the new period; and

(B) Any adjustment attributable to changes in age, except an additional adjustment may be made to reflect the provision of benefits not required to be covered by [*the basic*] **a standard value-based** health benefit plan and differences in family composition.

(e) Premium rates for health benefit plans shall comply with the requirements of this section.

[*(9)*] **(10)** In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

(a) The full array of health benefit plans that are offered to small employers by the carrier;

(b) The authority of the carrier to adjust rates, and the extent to which the carrier will consider age, family composition and geographic factors in establishing and adjusting rates;

(c) Provisions relating to renewability of policies and contracts; and

(d) Provisions affecting any preexisting conditions provision.

[*(10)(a)*] **(11)(a)** Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the director at least once every 12 months an actuarial certification that the carrier is in compliance with ORS 743.733 to 743.737 and that the rating methods of the small employer carrier are actuarially sound. Each such certification shall be in a uniform form and manner and shall contain such information as specified by the director. A copy of such certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in paragraph (a) of this subsection available to the director upon request. Except as provided in ORS 743.018 and except in cases of violations of ORS 743.733 to 743.737, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside the Department of Consumer and Business Services except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

[*(11)*] **(12)** A small employer carrier shall not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to market and sell health benefit plans of the carrier to small employer groups based on a small employer group's anticipated claims experience.

[*(12)*] **(13)** For purposes of this section, the date a small employer health benefit plan is continued shall be the anniversary date of the first issuance of the health benefit plan.

[*(13)*] **(14)** A small employer [*carrier*] **health benefit plan** must [*include a provision that offers*] **offer** coverage to all eligible employees and**, if** [*to all dependents to the extent*] the employer chooses to offer coverage to dependents**, to all dependents**.

[*(14)*] **(15)** All small employer health benefit plans shall contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided in 42 U.S.C. 300gg as amended and in effect on July 1, 1997.

SECTION 73. ORS 743.745 is amended to read:

743.745. The Director of the Department of Consumer and Business Services shall appoint a Health Insurance Reform Advisory Committee. This committee shall consist of at least one insurance producer, one representative of a health maintenance organization, one representative of a health care service contractor, one representative of a domestic insurer, one representative of a labor organization and one representative of consumer interests and shall have representation from the broad range of interests involved in the small employer and individual market and shall include members with the technical expertise necessary to carry out the following duties:

(1)(a) Subject to approval by the director, the committee shall recommend the form and level of coverages under [*the basic*] **standard value-based** health benefit plans pursuant to ORS 743.736 to be made available by small employer carriers and the portability health benefit plans to be made available pursuant to ORS 743.760 or 743.761. The committee shall take into consideration the levels of health benefit plans provided in Oregon and the appropriate medical and economic factors and shall establish benefit levels, cost sharing, exclusions and limitations. The health benefit plans described in this section may include cost containment features including, but not limited to:

(A) Preferred provider provisions;

(B) Utilization review of health care services including review of medical necessity of hospital and physician services;

(C) Case management benefit alternatives;

(D) Other managed care provisions;

(E) Selective contracting with hospitals, physicians and other health care providers; and

(F) Reasonable benefit differentials applicable to participating and nonparticipating providers.

(b) The committee shall submit the basic and portability health benefit plans and other recommendations to the director within the time period established by the director. The health benefit plans and other recommendations shall be deemed approved unless expressly disapproved by the director within 30 days after the date the director receives the plans.

(2) In order to ensure the broadest availability of small employer and individual health benefit plans, the committee shall recommend for approval by the director market conduct and other requirements for carriers and insurance producers, including requirements developed as a result of a request by the director, relating to the following:

(a) Registration by each carrier with the Department of Consumer and Business Services of its intention to be a small employer carrier under ORS 743.733 to 743.737 or a carrier offering individual health benefit plans, or both.

(b) Publication by the Department of Consumer and Business Services or the committee of a list of all small employer carriers and carriers offering individual health benefit plans, including a potential requirement applicable to insurance producers and carriers that no health benefit plan be sold to a small employer or individual by a carrier not so identified as a small employer carrier or carrier offering individual health benefit plans.

(c) To the extent deemed necessary by the committee to ensure the fair distribution of high-risk

individuals and groups among carriers, periodic reports by carriers and insurance producers concerning small employer, portability and individual health benefit plans issued, provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued, or both, to small employers and individuals.

(d) Methods concerning periodic demonstration by small employer carriers, carriers offering individual health benefit plans and insurance producers that the small employer and individual carriers are marketing or issuing, or both, health benefit plans to small employers or individuals in fulfillment of the purposes of ORS 743.730 to 743.773.

(3) Subject to the approval of the Director of the Department of Consumer and Business Services, the committee shall develop a standard health statement to be used for all late enrollees and by all carriers offering individual policies of health insurance.

(4) Subject to the approval of the director, the committee shall develop a list of the specified services for small employer and portability plans for which carriers may impose an exclusion period, the duration of the allowable exclusion period for each specified service and the manner in which credit will be given for exclusion periods imposed pursuant to prior health insurance coverage.

SECTION 73a. ORS 743.760 is amended to read:

743.760. (1) As used in this section:

(a) "Carrier" means an insurer authorized to issue a policy of health insurance in this state. "Carrier" does not include a multiple employer welfare arrangement.

(b)(A) "Eligible individual" means an individual who:

(i) Has left coverage that was continuously in effect for a period of 180 days or more under one or more Oregon group health benefit plans, has applied for portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident at the time of such application; or

(ii) On or after January 1, 1998, meets the eligibility requirements of 42 U.S.C. 300gg-41, as amended and in effect on January 1, 1998, has applied for portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident at the time of such application.

(B) Except as provided in subsection (12) of this section, "eligible individual" does not include 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, or who is covered under another health benefit plan at the time that portability coverage would commence or is eligible for the federal Medicare program.

(c) "Portability health benefit plans" and "portability plans" mean health benefit plans for eligible individuals that are required to be offered by all carriers offering group health benefit plans and that have been approved by the Director of the Department of Consumer and Business Services in accordance with this section.

(2)(a) In order to improve the availability and affordability of health benefit plans for individuals leaving coverage under group health benefit plans, the Health Insurance Reform Advisory Committee created under ORS 743.745 shall submit to the director two portability health benefit plans pursuant to ORS 743.745. One plan shall be in the form of insurance and the second plan shall be consistent with the type of coverage provided by health maintenance organizations. For each type of portability plan, the committee shall design and submit to the director:

(A) A prevailing benefit plan, which shall reflect the benefit coverages that are prevalent in the group health insurance market; and

(B) A low cost benefit plan, which shall emphasize affordability for eligible individuals.

(b) Except as provided in ORS 743.730 to 743.773, no law requiring the coverage or the offer of coverage of a health care service or benefit shall apply to portability health benefit plans.

(3) The director shall approve the portability health benefit plans if the director determines that the plans provide for appropriate accessibility and affordability of needed health care services and comply with all other provisions of this section.

(4) After the director's approval of the portability plans submitted by the committee under this section, each carrier offering group health benefit plans shall submit to the director the policy form or forms containing at least one low cost benefit and one prevailing benefit portability plan offered by the carrier that meets the required standards. Each policy form must be submitted as prescribed by the director and is subject to review and approval pursuant to ORS 742.003.

(5) Within 180 days after approval by the director of the portability plans submitted by the committee, as a condition of transacting group health insurance in this state, each carrier offering group health benefit plans shall make available to eligible individuals the prevailing benefit and low cost benefit portability plans that have been submitted by the carrier and approved by the director under subsection (4) of this section.

(6) A carrier offering group health benefit plans shall issue to an eligible individual who is leaving or has left group coverage provided by that carrier any portability plan offered by the carrier if the eligible individual applies for the plan within 63 days of termination of prior coverage and agrees to make the required premium payments and to satisfy the other provisions of the portability plan.

(7) Premium rates for portability plans **require approval by the director under ORS 742.003 and** shall be subject **to section 52b of this 2009 Act and** to the following provisions:

(a) Each carrier must file the geographic average rate for each of its portability health benefit plans for a rating period with the director on or before March 15 of each year.

(b) The premium rates charged during the rating period for each portability health benefit plan shall not vary from the geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age. Adjustments for age shall comply with the following:

(A) For each plan, the variation between the lowest premium rate and the highest premium rate shall not exceed 100 percent of the lowest premium rate.

(B) Premium variations shall be determined by applying uniformly the carrier's schedule of age adjustments for portability plans as approved by the director.

(c) Premium variations between the portability plans and the rest of the carrier's group plans must be based solely on objective differences in plan design or coverage and must not include differences based on the actual or expected health status of individuals who select portability health benefit plans. For purposes of determining the premium variations under this paragraph, a carrier may:

(A) Pool all portability plans with all group health benefit plans; or

(B) Pool all portability plans for eligible individuals leaving small employer group health benefit plan coverage with all plans offered to small employers and pool all portability plans for eligible individuals leaving other group health benefit plan coverage with all health benefit plans offered to such other groups.

(d) A carrier may not increase the rates of a portability plan issued to an enrollee more than once in any 12-month period. Annual rate increases shall be effective on the anniversary date of the plan issued to the enrollee. The percentage increase in the premium rate charged to an enrollee for a new rating period may not exceed the average increase in the rest of the carrier's applicable group health benefit plans plus an adjustment for age.

(8) No portability plans under this section may contain preexisting conditions provisions, exclusion periods, waiting periods or other similar limitations on coverage.

(9) Portability health benefit plans shall be renewable with respect to all enrollees at the option of the enrollee, except:

(a) For nonpayment of the required premiums by the policyholder;

(b) For fraud or misrepresentation by the policyholder;

(c) When the carrier elects to discontinue offering all of its group health benefit plans in accordance with ORS 743.737 and 743.754; or

(d) When the director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet its contractual obligations.

(10)(a) Each carrier offering group health benefit plans shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices relating to its portability plans, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) Each such carrier shall file with the director annually on or before March 15 an actuarial certification that the carrier is in compliance with this section and that its rating methods are actuarially sound. Each such certification shall be in a form and manner and shall contain such information as specified by the director. A copy of such certification shall be retained by the carrier at its principal place of business.

(c) Each such carrier shall make the information and documentation described in paragraph (a) of this subsection available to the director upon request. Except as provided in ORS 743.018 and except in cases of violations of the Insurance Code, the information is proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside the Department of Consumer and Business Services except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(11) A carrier offering group health benefit plans shall not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to market and sell portability plans of the carrier on the basis of an eligible individual's anticipated claims experience.

(12) An individual who is eligible to obtain a portability plan in accordance with this section may obtain such a plan regardless of whether the eligible individual qualifies for a period of continuation coverage under federal law or under ORS 743.600 or 743.610. However, an individual who has elected such continuation coverage is not eligible to obtain a portability plan until the continuation coverage has been discontinued by the individual or has been exhausted.

SECTION 73b. ORS 743.767 is amended to read:

743.767. Premium rates for individual health benefit plans **require approval by the Director of the Department of Consumer and Business Services under ORS 742.003 and** shall be subject to **section 52b of this 2009 Act and** the following provisions:

(1) Each carrier must file the geographic average rate for its individual health benefit plans for a rating period with the director [*of the Department of Consumer and Business Services*] on or before March 15 of each year.

(2) The premium rates charged during a rating period for individual health benefit plans issued to individuals shall not vary from the individual geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age. For age adjustments to the individual plans, a carrier shall apply uniformly its schedule of age adjustments for individual health benefit plans as approved by the director.

(3) A carrier may not increase the rates of an individual health benefit plan more than once in a 12-month period except as approved by the director. Annual rate increases shall be effective on the anniversary date of the individual health benefit plan's issuance. The percentage increase in the premium rate charged for an individual health benefit plan for a new rating period may not exceed the sum of the following:

(a) The percentage change in the carrier's geographic average rate for its individual health benefit plan measured from the first day of the prior rating period to the first day of the new period; and

(b) Any adjustment attributable to changes in age and differences in benefit design and family composition.

(4) Notwithstanding any other provision of this section, a carrier that imposes an individual coverage waiting period pursuant to ORS 743.766 may impose a monthly premium rate surcharge for a period not to exceed six months and in an amount not to exceed the percentage by which the rates for coverage under the Oregon Medical Insurance Pool exceed the rates established by the Oregon Medical Insurance Pool Board as applicable for individual risks under ORS 735.625. The surcharge shall be approved by the Director of the Department of Consumer and Business Services and, in combination with the waiting period, shall not exceed the actuarial value of a six-month preexisting conditions provision.

SECTION 73c. ORS 750.055, as amended by section 5, chapter 22, Oregon Laws 2008, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804 and 731.844 to 731.992 and section 2, chapter 22, Oregon Laws 2008.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.664, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.913, 743A.010, 743A.012, 743A.036, 743A.048, 743A.062, 743A.064, 743A.066, 743A.068, 743A.070,

743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.110, 743A.140, 743A.148, 743A.160, 743A.164, 743A.168, 743A.184, 743A.188 and 743A.190 **and sections 52b and 52c of this 2009 Act**.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

(g) ORS 746.005 to 746.140, 746.160, 746.220 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.

(h) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 73d. ORS 750.055, as amended by section 7, chapter 137, Oregon Laws 2003, section 3, chapter 263, Oregon Laws 2003, sections 501 and 502, chapter 22, Oregon Laws 2005, sections 5 and 6, chapter 255, Oregon Laws 2005, section 5, chapter 418, Oregon Laws 2005, section 3, chapter 128, Oregon Laws 2007, section 9, chapter 182, Oregon Laws 2007, section 6, chapter 313, Oregon Laws 2007, section 4, chapter 504, Oregon Laws 2007, section 4, chapter 566, Oregon Laws 2007, section 4, chapter 872, Oregon Laws 2007, and section 6, chapter 22, Oregon Laws 2008, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804 and 731.844 to 731.992 and section 2, chapter 22, Oregon Laws 2008.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911,

743.913, 743A.010, 743A.012, 743A.036, 743A.048, 743A.062, 743A.064, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.110, 743A.140, 743A.148, 743A.160, 743A.164, 743A.168, 743A.184 and 743A.190 **and sections 52b and 52c of this 2009 Act**.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

(g) ORS 746.005 to 746.140, 746.160, 746.220 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.

(h) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 73e. ORS 750.333, as amended by section 7, chapter 22, Oregon Laws 2008, is amended to read:

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652 and 731.804 to 731.992.

(b) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743A.012, 743A.064, 743A.080, 743A.100, 743A.104, 743A.110 and 743A.184.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.044, 743A.048, 743A.066, 743A.068, 743A.084, 743A.088, 743A.090, 743A.140, 743A.148, 743A.168, 743A.180, 743A.188 and 743A.190 **and sections 52b and 52c of this 2009 Act**. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

(h) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

(i) ORS 731.592 and 731.594.

(j) Section 2, chapter 22, Oregon Laws 2008.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

SECTION 73f. ORS 750.333, as amended by section 4, chapter 263, Oregon Laws 2003, section 11, chapter 182, Oregon Laws 2007, section 8, chapter 313, Oregon Laws 2007, section 6, chapter 504, Oregon Laws 2007, section 6, chapter 566, Oregon Laws 2007, section 6, chapter 872, Oregon Laws 2007, and section 8, chapter 22, Oregon Laws 2008, is amended to read:

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652 and 731.804 to 731.992.

(b) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743A.012, 743A.064, 743A.080, 743A.100, 743A.104, 743A.110 and 743A.184.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.044, 743A.048, 743A.066, 743A.068, 743A.084, 743A.088, 743A.090, 743A.140, 743A.148, 743A.168, 743A.180 and 743A.190 **and sections 52b and 52c of this 2009 Act**. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

(h) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

(i) ORS 731.592 and 731.594.

(j) Section 2, chapter 22, Oregon Laws 2008.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

SECTION 73g. ORS 750.333, as amended by section 8, chapter 137, Oregon Laws 2003, section

4, chapter 263, Oregon Laws 2003, section 3, chapter 446, Oregon Laws 2003, section 6, chapter 418, Oregon Laws 2005, section 12, chapter 182, Oregon Laws 2007, section 9, chapter 313, Oregon Laws 2007, section 7, chapter 504, Oregon Laws 2007, section 7, chapter 566, Oregon Laws 2007, section 7, chapter 872, Oregon Laws 2007, and section 9, chapter 22, Oregon Laws 2008, is amended to read:

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652 and 731.804 to 731.992.

(b) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743A.012, 743A.064, 743A.080, 743A.100, 743A.104, 743A.110 and 743A.184.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048, 743A.066, 743A.068, 743A.084, 743A.088, 743A.090, 743A.140, 743A.148, 743A.168, 743A.180 and 743A.190 **and sections 52b and 52c of this 2009 Act**. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

(h) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

(i) ORS 731.592 and 731.594.

(j) Section 2, chapter 22, Oregon Laws 2008.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

SECTION 74. Section 27, chapter 697, Oregon Laws 2007, is amended to read:

Sec. 27. Sections 1 to 13**, chapter 697, Oregon Laws 2007,** [*of this 2007 Act*] are repealed on [*January 2, 2010*] **the effective date of this 2009 Act**.

SECTION 75. The amendments to section 24 of this 2009 Act by section 25 of this 2009 Act become operative on July 1, 2011.

SECTION 76. Sections 52b and 52c of this 2009 Act and the amendments to ORS 743.018 by section 52d of this 2009 Act apply to premium rate filings for health insurance policies or certificates issued or renewed on or after April 1, 2010.

SECTION 77. ORS 414.031, 442.035, 442.045, 442.057 and 744.714 are repealed.

CAPTIONS AND EMERGENCY CLAUSE

SECTION 78. **The unit captions used in this 2009 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 2009 Act.**

SECTION 79. **This 2009 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2009 Act takes effect on its passage.**