House Bill 2918

Sponsored by Representative NOLAN; Representatives BARKER, GELSER (Presession filed.)

SUMMARY

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

Creates Small Business Health Insurance Pool in Oregon Health Authority, to be administered by Oregon Medical Insurance Pool Board. Specifies conditions for participation in pool. Authorizes board to adopt rules and to contract with insurers to provide coverage under pool. Establishes Small Business Health Insurance Pool Fund. Continuously appropriates moneys from fund to board to implement and operate pool. Becomes operative January 1, 2012.

Permits small businesses to participate in Oregon Prescription Drug Program.

Requires small employer carriers to provide written notification of proposed rate increase 30 days before increased premium payment is due.

Requires Oregon Business Development Department to provide link on website to health care resources for small businesses, including Healthy Kids program.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to small businesses; creating new provisions; amending ORS 414.312, 735.610 and 743.737; appropriating money; and declaring an emergency.

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

SECTION 1. Sections 2 to 4 of this 2011 Act are added to and made a part of the Insurance Code.

SECTION 2. (1) The Small Business Health Insurance Pool is established in the Oregon Health Authority. The pool shall be administered by the Oregon Medical Insurance Pool Board created under ORS 735.610. The purpose of the pool is to provide quality, affordable health insurance coverage to small employers in this state.

(2) An employer is eligible to participate in the pool if the employer has no more than 50 employees and agrees to be bound by the terms and conditions of the pool, including but not limited to an agreement to offer coverage to all employees on equal terms. The board may establish exception criteria by rule.

(3) The board shall establish by rule:

(a) The minimum benefits that must be offered by insurers participating in the pool;

(b) The cost of premiums;

(c) Eligibility and enrollment procedures;

(d) Copayments or other cost-sharing; and

(e) Other terms and conditions for participation by insurers and small employers in the pool.

SECTION 3. (1) The Oregon Medical Insurance Pool Board shall contract with one or more insurers to offer coverage through the Small Business Health Insurance Pool. The participating insurers shall be selected through a competitive bidding process. The board shall evaluate submitted bids based on criteria established by the board that include but are not limited to:

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.

(a) The insurer's proven ability to handle small employer group health insurance.

(b) The efficiency of the insurer's claim-paying procedures.

(c) An estimate of total charges for administering the coverage.

(d) The insurer's ability to administer the coverage in a cost-effective manner.

(2)(a) The participating insurers shall serve for a period of three years subject to removal for cause.

(b) At least one year prior to the expiration of each three-year period of service by a participating insurer, the board shall invite all insurers, including the current participating insurers, to submit bids to provide coverage through the pool for the succeeding three-year period. Selection of the participating insurers for the succeeding period shall be made at least six months prior to the end of the current three-year period.

(3) The board shall permit licensed insurance producers to assist small employers in selecting plans available through the pool and to enroll small employers and their employees.

(4) The board may contract with third party administrators or other vendors to establish and maintain a billing procedure for collection of premiums from small employers on a periodic basis as determined by the board.

(5) The board may establish fees for insurers participating in the pool to offset the board's administrative costs.

SECTION 4. (1) There is established in the State Treasury, separate and distinct from the General Fund, the Small Business Health Insurance Pool Fund consisting of:

(a) Moneys appropriated to the fund by the Legislative Assembly to carry out the provisions of sections 2 and 3 of this 2011 Act; and

(b) Premiums or other fees established by the Oregon Medical Insurance Pool Board that are collected from small employers and insurers participating in the Small Business Health Insurance Pool.

(2) Moneys in the Small Business Health Insurance Pool Fund are continuously appropriated to the Oregon Medical Insurance Pool Board to implement and operate the Small Business Health Insurance Pool, including but not limited to the payment of premiums to insurers participating in the pool.

SECTION 5. ORS 735.610 is amended to read:

735.610. (1) There is created in the Oregon Health Authority the Oregon Medical Insurance Pool Board. The board shall [*establish*] **administer** the Oregon Medical Insurance Pool **and the Small Business Health Insurance Pool** and otherwise carry out the responsibilities of the board under ORS 735.600 to 735.650 **and sections 2 to 4 of this 2011 Act**.

(2) The board shall consist of nine individuals, seven of whom shall be appointed by the Director of the Oregon Health Authority. The Director of the Department of Consumer and Business Services or the director's designee and the Director of the Oregon Health Authority or the director's designee shall be members of the board. The chair of the board shall be elected from among the members of the board. The board shall at all times, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care service contractor, one representative of a health maintenance organization, one representative of reinsurers and two members of the general public who are not associated with the medical profession, a hospital or an insurer. A majority of the voting members of the board constitutes a quorum for the transaction of business. An act by a majority of a quorum is an official act of the board.

(3) The Director of the Oregon Health Authority may fill any vacancy on the board by appointment.

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

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of ORS 735.600 to 735.650 **and sections 2 to 4 of this 2011 Act,** including the authority to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

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

(c) Take such legal action as is necessary to avoid the payment of improper claims against the [*pool*] **Oregon Medical Insurance Pool or the Small Business Health Insurance Pool** or the coverage provided by or through the [*pool*] **Oregon Medical Insurance Pool or the Small Business Health Insurance Pool**;

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

(e) Issue policies of insurance in accordance with the requirements of ORS 735.600 to 735.650 **and sections 2 to 4 of this 2011 Act**;

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

(g) Seek advances to effect the purposes of the [*pool*] **pools**; and

(h) Establish rules, conditions and procedures for reinsuring risks under ORS 735.600 to 735.650 **and sections 2 to 4 of this 2011 Act**.

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

(6) The Director of the Oregon Health Authority shall adopt rules, as provided under ORS chapter 183, implementing policies recommended by the board for the purpose of carrying out ORS 735.600 to 735.650 **and sections 2 to 4 of this 2011 Act**.

(7) In consultation with the board, the Director of the Oregon Health Authority shall employ such staff and consultants as may be necessary for the purpose of carrying out responsibilities under ORS 735.600 to 735.650 **and sections 2 to 4 of this 2011 Act**.

SECTION 6. Sections 2 to 4 of this 2011 Act and the amendments to ORS 735.610 by section 5 of this 2011 Act become operative January 1, 2012.

SECTION 7. The Oregon Medical Insurance Pool Board may take any action before the operative date specified in section 6 of this 2011 Act to enable the board to implement the provisions of sections 2 to 4 of this 2011 Act and the amendments to ORS 735.610 by section 5 of this 2011 Act on the operative date specified in section 6 of this 2011 Act.

SECTION 8. The Oregon Business Development Department shall include on a website maintained by the department links to health care resources for small employers doing business in Oregon, including but not limited to a link to the private health option of the Health Care for All Oregon Children program that is administered by the Office of Private Health Partnerships under ORS 414.826.

SECTION 9. ORS 414.312 is amended to read:

414.312. (1) As used in ORS 414.312 to 414.318:

(a) "Pharmacy benefit manager" means an entity that negotiates and executes contracts with pharmacies, manages preferred drug lists, negotiates rebates with prescription drug manufacturers and serves as an intermediary between the Oregon Prescription Drug Program, prescription drug manufacturers and pharmacies.

(b) "Prescription drug claims processor" means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the Oregon Prescription Drug Program and processes related payments to pharmacies.

(c) "Program price" means the reimbursement rates and prescription drug prices established by the administrator of the Oregon Prescription Drug Program.

(2) The Oregon Prescription Drug Program is established in the Oregon Health Authority. The purpose of the program is to:

(a) Purchase prescription drugs, replenish prescription drugs dispensed or reimburse pharmacies for prescription drugs in order to receive discounted prices and rebates;

(b) Make prescription drugs available at the lowest possible cost to participants in the program as a means to promote health;

(c) Maintain a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices; and

(d) Promote health through the purchase and provision of discount prescription drugs and coordination of comprehensive prescription benefit services for eligible entities and members.

(3) The Director of the Oregon Health Authority shall appoint an administrator of the Oregon Prescription Drug Program. The administrator may:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers or group purchasing organizations;

(b) Purchase prescription drugs on behalf of individuals and entities that participate in the program;

(c) Contract with a prescription drug claims processor to adjudicate pharmacy claims and transmit program prices to pharmacies;

(d) Determine program prices and reimburse or replenish pharmacies for prescription drugs dispensed or transferred;

(e) Adopt and implement a preferred drug list for the program;

(f) Develop a system for allocating and distributing the operational costs of the program and any rebates obtained to participants of the program; and

(g) Cooperate with other states or regional consortia in the bulk purchase of prescription drugs.

(4) The following individuals or entities may participate in the program:

(a) Public Employees' Benefit Board, Oregon Educators Benefit Board and Public Employees Retirement System;

(b) Local governments as defined in ORS 174.116 and special government bodies as defined in

ORS 174.117 that directly or indirectly purchase prescription drugs;

(c) Oregon Health and Science University established under ORS 353.020;

(d) State agencies that directly or indirectly purchase prescription drugs, including agencies that dispense prescription drugs directly to persons in state-operated facilities;

(e) Residents of this state who lack or are underinsured for prescription drug coverage;

(f) Private entities**, including small employers as defined in ORS 735.700**; and

(g) Labor organizations.

(5) The state agency that receives federal Medicaid funds and is responsible for implementing the state's medical assistance program may not participate in the program.

(6) The administrator may establish different program prices for pharmacies in rural areas to maintain statewide access to the program.

(7) The administrator may establish the terms and conditions for a pharmacy to enroll in the program. A licensed pharmacy that is willing to accept the terms and conditions established by the administrator may apply to enroll in the program.

(8) Except as provided in subsection (10) of this section, the administrator may not:

(a) Contract with a pharmacy benefit manager;

(b) Establish a state-managed wholesale or retail drug distribution or dispensing system; or

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program.

(9) The administrator shall contract with one or more entities to perform any of the functions of the program, including but not limited to:

(a) Contracting with a pharmacy benefit manager and directly or indirectly with such pharmacy networks as the administrator considers necessary to maintain statewide access to the program.

(b) Negotiating with prescription drug manufacturers on behalf of the administrator.

(10) Notwithstanding subsection (4)(e) of this section, individuals who are eligible for Medicare Part D prescription drug coverage may participate in the program.

(11) The program may contract with vendors as necessary to utilize discount purchasing programs, including but not limited to group purchasing organizations established to meet the criteria of the Nonprofit Institutions Act, 15 U.S.C. 13c, or that are exempt under the Robinson-Patman Act, 15 U.S.C. 13.

SECTION 10. 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 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) 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.

(6) Notwithstanding any provision of subsection (5) 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) 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 medical assistance program under ORS chapter 414.

(8) Premium rates for small employer health benefit plans shall be subject to 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 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 between 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 health benefit plan and differences in family composition.

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

(9) 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) 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) 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) 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) A small employer carrier must include a provision that offers coverage to all eligible employees and to all dependents to the extent the employer chooses to offer coverage to dependents.

(14) 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.

(15) A small employer carrier shall provide written notification of any proposed rate increase to a small employer no less than 30 days before the date that the increased premium payment is due.

SECTION 11. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.