

A-Engrossed Senate Bill 89

Ordered by the Senate April 29
Including Senate Amendments dated April 29

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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.

[Authorizes Department of Consumer and Business Services to enforce health insurance requirements of federal law. Modifies definition of "health benefit plan" and includes student health insurance within definition. Prohibits health insurer from canceling, rescinding or refusing to renew policy on or after September 23, 2010, except for fraud or intentional misrepresentation of material fact. Requires health insurers to notify covered persons and department regarding rescinded policies on or after September 23, 2010. Prohibits preexisting condition exclusion for insureds under 19 years of age who are enrolled in certain types of health insurance. Requires coverage of federally specified preventive health services and limited cost-sharing for preventive services in health benefit plans issued on or after September 23, 2010. Prohibits health insurers from offering rate differentials for highly compensated employees. Removes exception for association health plans from specified provisions of Insurance Code. Prohibits lifetime dollar limits on essential health benefits covered by health insurance. Imposes new requirements for internal and external review of adverse benefit determinations in health benefit plans offered or renewed on or after September 23, 2010. Allows enrollee to seek external review through Director of Department of Consumer and Business Services. Requires insurers to allow female enrollee access to obstetrical or gynecological care without referral or prior authorization.]

Requires certain health benefit plans to provide coverage of preventive health services as prescribed by United States Department of Health and Human Services and prohibits those plans from imposing cost-sharing requirements on enrollees for preventive health services. Prohibits health insurer from canceling, rescinding or refusing to renew policy on or after September 23, 2010, except for nonpayment, fraud or intentional misrepresentation of material fact. Requires health insurers to notify covered persons and Department of Consumer and Business Services regarding rescinded policies on or after September 23, 2010. Prohibits preexisting condition exclusion for insureds under 19 years of age who are enrolled in certain types of health insurance. Exempts health benefit plan issued to small employer group through association health plan from application of certain provisions. Prohibits annual or lifetime dollar limits on essential health benefits covered by health insurance. Imposes new requirements for internal review and external appeal of adverse benefit determinations in health benefit plans offered or renewed on or after September 23, 2010. Requires insurers to allow female enrollee access to obstetrical or gynecological care without referral or prior authorization. Modifies requirements relating to coverage of emergency services and pregnancy care.

Abolishes Health Insurance Reform Advisory Committee.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to health insurance; creating new provisions; amending ORS 413.032, 743.405, 743.730,
3 743.731, 743.733, 743.734, 743.736, 743.737, 743.745, 743.748, 743.751, 743.754, 743.758, 743.760,
4 743.761, 743.766, 743.767, 743.801, 743.804, 743.806, 743.807, 743.845, 743.857, 743.859, 743.861,
5 743.862, 743.863, 743.864, 743.878, 743A.012, 743A.080, 743A.090, 743A.110, 746.650, 750.055 and
6 750.333 and sections 12 and 13, chapter 752, Oregon Laws 2007, and section 4, chapter 75,
7 Oregon Laws 2010; and declaring an emergency.

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

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

1 **SECTION 1.** Section 2 of this 2011 Act is added to and made a part of ORS 743.730 to
2 **743.773.**

3 **SECTION 2.** Notwithstanding any other provision of law, a health benefit plan that is not
4 a grandfathered health plan:

5 (1) Must provide coverage of preventive health services as prescribed by the United
6 States Department of Health and Human Services pursuant to 42 U.S.C. 300gg-13; and

7 (2) May not impose cost-sharing requirements on an enrollee for preventive health ser-
8 vices, except as allowed by federal law.

9 **SECTION 3.** Section 4 of this 2011 Act is added to and made a part of the Insurance Code.

10 **SECTION 4.** (1) As used in this section, “rescind” means to retroactively cancel or dis-
11 continue coverage under a health benefit plan or group or individual health insurance policy
12 for reasons other than failure to timely pay required premiums or required contributions
13 toward the cost of coverage.

14 (2) An insurer may not rescind coverage of an individual or the group to which an indi-
15 vidual belongs under a health benefit plan or group or individual health insurance policy
16 unless:

17 (a)(A) The individual or a representative of the individual performs an act, practice or
18 omission that constitutes fraud; or

19 (B) The individual makes an intentional misrepresentation of a material fact as prohib-
20 ited by the terms of the plan or policy; and

21 (b) The insurer provides at least 30 days’ advance written notice, in the form and manner
22 prescribed by the Department of Consumer and Business Services, to each plan enrollee or
23 policy holder who would be affected by the rescission of coverage.

24 (3) An insurer that rescinds a plan or policy must provide notice of the rescission to the
25 department in the form, manner and time frame prescribed by the department by rule.

26 **SECTION 5.** ORS 413.032 is amended to read:

27 413.032. (1) The Oregon Health Authority is established. The authority shall:

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

29 (b) Develop a plan for the Oregon Health Insurance Exchange in accordance with section 17,
30 chapter 595, Oregon Laws 2009;

31 (c) Administer the Oregon Prescription Drug Program;

32 (d) Administer the Family Health Insurance Assistance Program;

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

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

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

40 (h) In consultation with the Director of the Department of Consumer and Business Services,
41 periodically review and recommend standards and methodologies to the Legislative Assembly for:

42 (A) Review of administrative expenses of health insurers;

43 (B) Approval of rates; and

44 (C) Enforcement of rating rules adopted by the Department of Consumer and Business Services;

45 (i) Structure reimbursement rates for providers that serve recipients of medical assistance to

1 reward comprehensive management of diseases, quality outcomes and the efficient use of resources
2 and to promote cost-effective procedures, services and programs including, without limitation, pre-
3 ventive health, dental and primary care services, web-based office visits, telephone consultations and
4 telemedicine consultations;

5 (j) Guide and support community three-share agreements in which an employer, state or local
6 government and an individual all contribute a portion of a premium for a community-centered health
7 initiative or for insurance coverage; and

8 (k) Develop, in consultation with the Department of Consumer and Business Services [*and the*
9 *Health Insurance Reform Advisory Committee*], one or more products designed to provide more af-
10 fordable options for the small group market.

11 (2) The Oregon Health Authority is authorized to:

12 (a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate
13 health care reform in Oregon and to provide comparative cost and quality information to consumers,
14 providers and purchasers of health care about Oregon's health care systems and health plan net-
15 works in order to provide comparative information to consumers.

16 (b) Develop uniform contracting standards for the purchase of health care, including the fol-
17 lowing:

18 (A) Uniform quality standards and performance measures;

19 (B) Evidence-based guidelines for major chronic disease management and health care services
20 with unexplained variations in frequency or cost;

21 (C) Evidence-based effectiveness guidelines for select new technologies and medical equipment;
22 and

23 (D) A statewide drug formulary that may be used by publicly funded health benefit plans.

24 (c) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered
25 year, requests for measures necessary to provide statutory authorization to carry out any of the
26 authority's duties or to implement any of the board's recommendations. The measures may be filed
27 prior to the beginning of the legislative session in accordance with the rules of the House of Rep-
28 resentatives and the Senate.

29 (3) The enumeration of duties, functions and powers in this section is not intended to be exclu-
30 sive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Au-
31 thority by ORS 413.006 to 413.064 or by other statutes.

32 **SECTION 6.** ORS 743.405 is amended to read:

33 743.405. An individual health insurance policy must meet the following requirements:

34 (1) The entire money and other considerations therefor shall be expressed therein.

35 (2) The time at which the insurance takes effect and terminates shall be expressed therein.

36 (3) It shall purport to insure only one person, except that a policy may insure, originally or by
37 subsequent amendment, upon the application of an adult member of a family who shall be deemed
38 the policyholder, any two or more eligible members of that family, including husband, wife, depend-
39 ent children or any children under a specified age[, *which shall not exceed 19 years,*] and any other
40 person dependent upon the policyholder.

41 (4) The policy may not be issued individually to an individual in a group of persons as described
42 in ORS 743.522 for the purpose of separating the individual from health insurance benefits offered
43 or provided in connection with a group health benefit plan.

44 (5) Except as provided in ORS 743.498, the style, arrangement and overall appearance of the
45 policy may not give undue prominence to any portion of the text, and every printed portion of the

1 text of the policy and of any indorsements or attached papers shall be plainly printed in lightfaced
2 type of a style in general use, the size of which shall be uniform and not less than 10 point with a
3 lower case unspaced alphabet length not less than 120 point. Captions shall be printed in not less
4 than 12-point type. As used in this subsection, "text" includes all printed matter except the name
5 and address of the insurer, name or title of the policy, the brief description if any, and captions and
6 subcaptions.

7 (6) The exceptions and reductions of indemnity must be set forth in the policy. Except those
8 required by ORS 743.411 to 743.477 [*and 743A.160*], exceptions and reductions shall be printed at the
9 insurer's option either included with the applicable benefit provision or under an appropriate cap-
10 tion such as EXCEPTIONS, or EXCEPTIONS AND REDUCTIONS. However, if an exception or re-
11 duction specifically applies only to a particular benefit of the policy, a statement of the exception
12 or reduction must be included with the applicable benefit provision.

13 (7) Each form constituting the policy, including riders and indorsements, must be identified by
14 a form number in the lower left-hand corner of the first page of the policy.

15 (8) The policy may not contain provisions purporting to make any portion of the charter, rules,
16 constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in
17 the policy, except in the case of the incorporation of or reference to a statement of rates or classi-
18 fication of risks, or short rate table filed with the Director of the Department of Consumer and
19 Business Services.

20 **SECTION 7.** ORS 743.730 is amended to read:

21 743.730. For purposes of ORS 743.730 to 743.773:

22 (1) "Actuarial certification" means a written statement by a member of the American Academy
23 of Actuaries or other individual acceptable to the Director of the Department of Consumer and
24 Business Services that a carrier is in compliance with the provisions of ORS 743.736, 743.760 or
25 743.761, based upon the person's examination, including a review of the appropriate records and of
26 the actuarial assumptions and methods used by the carrier in establishing premium rates for small
27 employer and portability health benefit plans.

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

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

34 (a) That is applied uniformly and without regard to any health status related factors to an
35 enrollee or late enrollee in lieu of a preexisting [*conditions provision*] **condition exclusion**;

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

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

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

41 (4) "Basic health benefit plan" means a health benefit plan [*for small employers that is required*
42 *to be offered by all small employer carriers and approved by the Director of the Department of Con-*
43 *sumer and Business Services in accordance with ORS 743.736*] **approved by the Department of**
44 **Consumer and Business Services under ORS 743.736.**

45 (5) "Bona fide association" means an association that meets the requirements of 42 U.S.C.

1 [300gg-11] **300gg-91** as amended and in effect on [July 1, 1997] **March 23, 2010.**

2 (6) "Carrier," **except as provided in ORS 743.760**, means any person who provides health ben-
3 efit plans in this state, including a licensed insurance company, a health care service contractor, a
4 health maintenance organization, an association or group of employers that provides benefits by
5 means of a multiple employer welfare arrangement or any other person or corporation responsible
6 for the payment of benefits or provision of services.

7 [(7) "Committee" means the Health Insurance Reform Advisory Committee created under ORS
8 743.745.]

9 [(8) (7) "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg
10 as amended and in effect on [July 1, 1997] **February 17, 2009**, and includes coverage remaining in
11 force at the time the enrollee obtains new coverage.

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

13 [(10) (8) "Dependent" means the spouse or child of an eligible employee, subject to applicable
14 terms of the health benefit plan covering the employee.

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

16 [(12) (9) "Eligible employee" means an employee [of a small employer] who works on a regularly
17 scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours
18 worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. "Eligible
19 employee" does not include employees who work on a temporary, seasonal or substitute basis. Em-
20 ployees who have been employed by the [small] employer for fewer than 90 days are not eligible
21 employees unless the [small] employer so allows.

22 [(13) (10) "Employee" means any individual employed by an employer.

23 [(14) (11) "Enrollee" means an employee, dependent of the employee or an individual otherwise
24 eligible for a group, individual or portability health benefit plan who has enrolled for coverage under
25 the terms of the plan.

26 [(15) (12) "Exclusion period" means a period during which specified treatments or services are
27 excluded from coverage.

28 [(16) (13) "Financially impaired" means a [member] **carrier** that is not insolvent and is:

29 (a) Considered by the director [of the Department of Consumer and Business Services] to be po-
30 tentially unable to fulfill its contractual obligations; or

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

32 [(17)(a) (14)(a) "Geographic average rate" means the arithmetical average of the lowest pre-
33 mium and the corresponding highest premium to be charged by a carrier in a geographic area es-
34 tablished by the director for the carrier's:

35 (A) [Small employer] Group health benefit plans;

36 (B) Individual health benefit plans; or

37 (C) Portability health benefit plans.

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

40 (15) "**Grandfathered health plan**" has the meaning prescribed by the United States Sec-
41 **retaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C.**
42 **18011(e).**

43 [(18) (16) "Group eligibility waiting period" means, with respect to a group health benefit plan,
44 the period of employment or membership with the group that a prospective enrollee must complete
45 before plan coverage begins.

1 [(19)(a)] (17)(a) “Health benefit plan” means any:

2 (A) Hospital expense, medical expense or hospital or medical expense policy or certificate[.];

3 (B) Health care service contractor or health maintenance organization subscriber contract[.
4 any]; or

5 (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-
6 ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, **to the**
7 **extent that the plan is subject to state regulation.**

8 (b) “Health benefit plan” does not include:

9 (A) Coverage for accident only, specific disease or condition only, credit[,] or disability
10 income[.];

11 (B) Coverage of Medicare services pursuant to contracts with the federal government[.];

12 (C) Medicare supplement insurance policies[.];

13 (D) Coverage of [CHAMPUS] TRICARE services pursuant to contracts with the federal
14 government[.];

15 (E) Benefits delivered through a flexible spending arrangement established pursuant to section
16 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition
17 to a group health benefit plan[.];

18 (F) **Separately offered long term care insurance, including, but not limited to, coverage of**
19 **nursing home care, home health care and community-based care;**

20 (G) [*hospital indemnity only,*] **Independent, noncoordinated, hospital-only indemnity insur-**
21 **ance or other fixed indemnity insurance;**

22 (H) Short term health insurance policies [*(the duration of which does not exceed six months in-*
23 *cluding renewals), student accident and health insurance policies,*] **that are in effect for periods of**
24 **12 months or less, including the term of a renewal of the policy;**

25 (I) Dental only[,] **coverage;**

26 (J) Vision only[,] **coverage;**

27 (K) [*a policy of*] Stop-loss coverage that meets the requirements of ORS 742.065[.];

28 (L) Coverage issued as a supplement to liability insurance[.];

29 (M) Insurance arising out of a workers’ compensation or similar law[.];

30 (N) Automobile medical payment insurance or insurance under which benefits are payable with
31 or without regard to fault and that is statutorily required to be contained in any liability insurance
32 policy or equivalent self-insurance[.]; or

33 (O) **Any employee welfare benefit plan that is exempt from state regulation because of**
34 **the federal Employee Retirement Income Security Act of 1974, as amended.**

35 [(c) *Nothing in this subsection shall be construed to regulate any employee welfare benefit plan that*
36 *is exempt from state regulation because of the federal Employee Retirement Income Security Act of*
37 *1974, as amended.*]

38 (c) **For purposes of this subsection, renewal of a short term health insurance policy in-**
39 **cludes the issuance of a new short term health insurance policy by an insurer to a**
40 **policyholder within 60 days after the expiration of a policy previously issued by the insurer**
41 **to the policyholder.**

42 [(20)] (18) “Health statement” means any information that is intended to inform the carrier or
43 insurance producer of the health status of an enrollee or prospective enrollee in a health benefit
44 plan. “Health statement” includes the standard health statement [*developed by the Health Insurance*
45 *Reform Advisory Committee*] **approved by the director under ORS 743.745.**

1 [(21) “Implementation of chapter 836, Oregon Laws 1989” means that the Health Services Com-
2 mission has prepared a priority list, the Legislative Assembly has enacted funding of the list and all
3 necessary federal approval, including waivers, has been obtained.]

4 [(22)] (19) “Individual coverage waiting period” means a period in an individual health benefit
5 plan during which no premiums may be collected and health benefit plan coverage issued is not ef-
6 fective.

7 [(23)] (20) “Initial enrollment period” means a period of at least 30 days following commence-
8 ment of the first eligibility period for an individual.

9 [(24)] (21) “Late enrollee” means an individual who enrolls in a group health benefit plan sub-
10 sequent to the initial enrollment period during which the individual was eligible for coverage but
11 declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

12 (a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg
13 as amended and in effect on [July 1, 1997] **February 17, 2009**;

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

15 (c) A court [has ordered] **issues an order** that coverage be provided for a spouse or minor child
16 under [a covered] **an** employee’s **employer sponsored** health benefit plan and request for enrollment
17 is made within 30 days after issuance of the court order;

18 (d) The individual is employed by an employer [who] **that** offers multiple health benefit plans
19 and the individual elects a different health benefit plan during an open enrollment period; or

20 (e) The individual’s coverage under Medicaid, Medicare, [CHAMPUS] **TRICARE**, Indian Health
21 Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical
22 assistance program under ORS chapter 414, has been involuntarily terminated within 63 days [of]
23 **after** applying for coverage in a group health benefit plan.

24 [(25)] (22) “Multiple employer welfare arrangement” means a multiple employer welfare ar-
25 rangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974,
26 as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

27 [(26)] (23) “Oregon Medical Insurance Pool” means the pool created under ORS 735.610.

28 [(27)] (24) “Preexisting [conditions provision] **condition exclusion**” means a health benefit plan
29 provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or
30 expenses incurred during a specified period immediately following enrollment for a condition for
31 which medical advice, diagnosis, care or treatment was recommended or received during a specified
32 period immediately preceding enrollment. For purposes of ORS 743.730 to 743.773:

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

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

36 (c) **Except for coverage under an individual grandfathered health plan**, a preexisting [con-
37 ditions provision shall not be applied to a newborn child or adopted child who obtains coverage in
38 accordance with ORS 743A.090] **condition exclusion may not exclude coverage for services,**
39 **charges or expenses incurred by an individual who is under 19 years of age.**

40 [(28)] (25) “Premium” includes insurance premiums or other fees charged for a health benefit
41 plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees cov-
42 ered by the plan.

43 [(29)] (26) “Rating period” means the 12-month calendar period for which premium rates estab-
44 lished by a carrier are in effect, as determined by the carrier.

45 (27) **“Representative” does not include an insurance producer or an employee or author-**

1 **ized representative of an insurance producer or carrier.**

2 [(30)(a)] **(28)(a)** “Small employer” means an employer that employed an average of at least two
3 but not more than 50 employees on business days during the preceding calendar year, the majority
4 of whom are employed within this state, and that employs at least two eligible employees on the date
5 on which coverage takes effect under a health benefit plan [issued by a small employer carrier] **of-**
6 **fered by the employer.**

7 [(b) Any person that is treated as a single employer under subsection (b), (c), (m) or (o) of section
8 414 of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this sub-
9 section.]

10 [(c)] **(b)** The determination of whether an employer that was not in existence throughout the
11 preceding calendar year is a small employer shall be based on the average number of employees that
12 it is reasonably expected the employer will employ on business days in the current calendar year.

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

17 **SECTION 8.** ORS 743.731 is amended to read:

18 743.731. The purposes of ORS 743.730 to 743.773 are:

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

21 (2) To prevent abusive rating practices;

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

24 (4) To establish limitations on the use of preexisting [conditions provisions] **condition exclu-**
25 **sions;**

26 (5) To make basic health benefit plans available to all small employers;

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

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

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

31 (9) To ensure that health insurance coverage in Oregon satisfies the requirements of the Health
32 Insurance Portability and Accountability Act of 1996 (P.L. 104-191) **and the Patient Protection and**
33 **Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconcil-**
34 **iation Act (P.L. 111-152),** and that enforcement authority for those requirements is retained by the
35 Director of the Department of Consumer and Business Services.

36 **SECTION 9.** ORS 743.733 is amended to read:

37 743.733. (1) If an affiliated group of employers is treated as a single employer under subsection
38 (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986, a carrier may issue a single
39 group health benefit plan to the affiliated group on the basis of the number of employees in the af-
40 filiated group if the group requests such coverage.

41 (2) If a [small employer] carrier determines that an employer has more than 50 employees, the
42 carrier may provide a quote for a group health benefit plan that is not subject to ORS 743.733 to
43 743.737. If the employer’s workforce consists of at least two but not more than 50 eligible employees,
44 the [small group] carrier shall inform the employer that if coverage is limited to the eligible em-
45 ployees, the carrier must treat the employer as a small employer and shall provide a separate quote

1 on that basis.

2 (3) Subsequent to the issuance of a health benefit plan to a small employer, a [*small employer*]
3 carrier shall determine annually the number of employees of the employer for purposes of deter-
4 mining the employer's ongoing eligibility as a small employer. The provisions of ORS 743.733 to
5 743.737 shall continue to apply to a health benefit plan issued to a small employer until the plan
6 anniversary date following the date the employer no longer meets the definition of a small employer.

7 **SECTION 10.** Section 13, chapter 752, Oregon Laws 2007, as amended by section 4, chapter 81,
8 Oregon Laws 2010, is amended to read:

9 **Sec. 13.** The amendments to ORS 731.146, 731.484, 731.486, 743.734 and 743.748 by sections 6 to
10 8 [*and 10*], chapter 752, Oregon Laws 2007, and [*section 3 of this 2010 Act*] **and sections 13 and 18**
11 **of this 2011 Act** become operative on January 2, 2014.

12 **SECTION 11.** Section 12, chapter 752, Oregon Laws 2007, is amended to read:

13 **Sec. 12.** [(1) ORS 743.734, as amended by section 4 of this 2007 Act, applies to health benefit plans
14 issued or renewed on or after the effective date of this 2007 Act and before January 2, 2014.]

15 [(2)] An association health plan issued to a group described in ORS 743.522 (2) prior to May 1,
16 2007, to an association or trust approved prior to May 1, 2007, or to a multiple employer welfare
17 arrangement authorized prior to May 1, 2007, is not subject to the requirements of ORS 743.734
18 (7)(b)(C) with respect to membership requirements in effect prior to May 1, 2007.

19 **SECTION 12.** ORS 743.734, as amended by section 9, chapter 752, Oregon Laws 2007, and
20 sections 2 and 3, chapter 81, Oregon Laws 2010, is amended to read:

21 743.734. (1) Every [*group*] health benefit plan shall be subject to the provisions of ORS 743.733
22 to 743.737, if the plan provides health benefits covering one or more employees of a small employer
23 and if any one of the following conditions is met:

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

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

30 (2) Except as provided in ORS 743.733 to 743.737 **and 743A.012 and section 2 of this 2011**
31 **Act**, no **state** law requiring the coverage or the offer of coverage of a health care service or benefit
32 applies to the basic health benefit plans offered or delivered to a small employer.

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

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

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

39 (4) Except to determine the application of a preexisting [*conditions provision*] **condition exclu-**
40 **sion** for a late enrollee **who is 19 years of age or older**, a [*small employer*] carrier shall not use
41 health statements when offering small employer health benefit plans and shall not use any other
42 method to determine the actual or expected health status of eligible enrollees. Nothing in this sub-
43 section shall prevent a carrier from using health statements or other information after enrollment
44 for the purpose of providing services or arranging for the provision of services under a health ben-
45 efit plan.

1 (5) Except *[in the case of a late enrollee and as otherwise provided in this section]* **as provided**
 2 **in this section and ORS 743.737**, a *[small employer]* carrier shall not impose different terms or
 3 conditions on the coverage, premiums or contributions of any eligible employee *[in]* **of** a small em-
 4 ployer *[group]* that are based on the actual or expected health status of any eligible employee.

5 (6)(a) A *[small employer]* carrier may provide different health benefit plans to different catego-
 6 ries of employees of a small employer **that has at least 26 but no more than 50 eligible em-**
 7 **ployees** when the employer has chosen to establish different categories of employees in a manner
 8 that does not relate to the actual or expected health status of such employees or their dependents.
 9 The categories must be based on bona fide employment-based classifications that are consistent with
 10 the employer's usual business practice. *[Except as provided in ORS 743.736 (10):]*

11 *[(a)]* (b) *[When]* **Except as provided in ORS 743.736 (9)**, a *[small employer]* carrier **that** offers
 12 coverage to a small employer with no more than 25 eligible employees, *[the small employer carrier]*
 13 shall offer coverage to all eligible employees of the small employer, without regard to the actual or
 14 expected health status of any eligible employee.

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

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

23 (7) **A health benefit plan issued to a small employer group through an association health**
 24 **plan is exempt from subsection (1) of this section. For purposes of this subsection, an asso-**
 25 **ciation health plan is group health insurance described in ORS 743.522 (2) or a health benefit**
 26 **plan that:**

27 (a) **Is delivered or issued for delivery to:**

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

31 (B) **An association or trust established in another state, that is approved by the Director**
 32 **of the Department of Consumer and Business Services under ORS 731.486 (7), or a multiple**
 33 **employer welfare arrangement located in another state that complies with ORS 750.311; and**

34 (b) **Satisfies all of the following:**

35 (A) **The initial premium rate for the association health plan does not vary by more than**
 36 **50 percent across the groups of small employers under the plan.**

37 (B) **The association policyholder does not discriminate in membership requirements based**
 38 **on actual or expected health status of individual enrollees or prospective enrollees, in ac-**
 39 **cordance with ORS 743.752 (5).**

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

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

45 (8)(a) **The 95 percent retention rate required under subsection (7) of this section does not**

1 **apply to employer groups that:**

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

3 **(B) No longer meet eligibility requirements for membership in the association, including**
4 **failure to pay association dues;**

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

7 **(D) Fail to pay premiums.**

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

11 **(c) The director may exempt an association health plan from the 95 percent retention**
12 **rate requirement in subsection (7) of this section according to criteria prescribed by the di-**
13 **rector by rule.**

14 **(9) Notwithstanding any other provision of law, an insurer may not deny, delay or ter-**
15 **minate participation of an individual in a group health benefit plan or exclude coverage oth-**
16 **erwise provided to an individual under a group health benefit plan based on a preexisting**
17 **condition of the individual if the individual is under 19 years of age.**

18 **SECTION 13.** ORS 743.734, as amended by section 9, chapter 752, Oregon Laws 2007, sections
19 2 and 3, chapter 81, Oregon Laws 2010, and section 12 of this 2011 Act, is amended to read:

20 743.734. (1) Every health benefit plan shall be subject to the provisions of ORS 743.733 to
21 743.737, if the plan provides health benefits covering one or more employees of a small employer and
22 if any one of the following conditions is met:

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

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

29 (2) Except as provided in ORS 743.733 to 743.737 and 743A.912 and section 2 of this 2011 Act,
30 no state law requiring the coverage or the offer of coverage of a health care service or benefit ap-
31 plies to the basic health benefit plans offered or delivered to a small employer.

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

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

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

38 (4) Except to determine the application of a preexisting condition exclusion for a late enrollee
39 who is 19 years of age or older, a carrier shall not use health statements when offering small em-
40 ployer health benefit plans and shall not use any other method to determine the actual or expected
41 health status of eligible enrollees. Nothing in this subsection shall prevent a carrier from using
42 health statements or other information after enrollment for the purpose of providing services or
43 arranging for the provision of services under a health benefit plan.

44 (5) Except as provided in this section and ORS 743.737, a carrier shall not impose different terms
45 or conditions on the coverage, premiums or contributions of any eligible employee of a small em-

1 ployer that are based on the actual or expected health status of any eligible employee.

2 (6)(a) A carrier may provide different health benefit plans to different categories of employees
3 of a small employer that has at least 26 but no more than 50 eligible employees when the employer
4 has chosen to establish different categories of employees in a manner that does not relate to the
5 actual or expected health status of such employees or their dependents. The categories must be
6 based on bona fide employment-based classifications that are consistent with the employer's usual
7 business practice.

8 (b) Except as provided in ORS 743.736 (9), a carrier that offers coverage to a small employer
9 with no more than 25 eligible employees shall offer coverage to all eligible employees of the small
10 employer, without regard to the actual or expected health status of any eligible employee.

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

14 *[(7) A health benefit plan issued to a small employer group through an association health plan is*
15 *exempt from subsection (1) of this section. For purposes of this subsection, an association health plan*
16 *is group health insurance described in ORS 743.522 (2) or a health benefit plan that:]*

17 *[(a) Is delivered or issued for delivery to:]*

18 *[(A) An association or trust established in this state, that meets applicable requirements of ORS*
19 *743.524 or 743.526, or to a multiple employer welfare arrangement located inside this state, subject to*
20 *ORS 750.301 to 750.341; or]*

21 *[(B) An association or trust established in another state, that is approved by the Director of the*
22 *Department of Consumer and Business Services under ORS 731.486 (7), or a multiple employer welfare*
23 *arrangement located in another state that complies with ORS 750.311; and]*

24 *[(b) Satisfies all of the following:]*

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

27 *[(B) The association policyholder does not discriminate in membership requirements based on ac-*
28 *tual or expected health status of individual enrollees or prospective enrollees, in accordance with ORS*
29 *743.752 (5).]*

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

32 *[(D) Except as provided in subsection (8) of this section, the association health plan maintains a*
33 *95 percent retention rate.]*

34 *[(8)(a) The 95 percent retention rate required under subsection (7) of this section does not apply to*
35 *employer groups that:]*

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

37 *[(B) No longer meet eligibility requirements for membership in the association, including failure to*
38 *pay association dues;]*

39 *[(C) No longer meet participation requirements for employers that are set forth in the plan docu-*
40 *ments; or]*

41 *[(D) Fail to pay premiums.]*

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

45 *[(c) The director may exempt an association health plan from the 95 percent retention rate re-*

1 *quirement in subsection (7) of this section according to criteria prescribed by the director by rule.]*

2 [(9)] (7) Notwithstanding any other provision of law, an insurer may not deny, delay or terminate
3 participation of an individual in a group health benefit plan or exclude coverage otherwise provided
4 to an individual under a group health benefit plan based on a preexisting condition of the individual
5 if the individual is under 19 years of age.

6 **SECTION 14.** ORS 743.736 is amended to read:

7 743.736. [(1) *In order to improve the availability and affordability of health benefit coverage for*
8 *small employers, the Health Insurance Reform Advisory Committee created under ORS 743.745 shall*
9 *submit to the Director of the Department of Consumer and Business Services two basic health benefit*
10 *plans pursuant to ORS 743.745. One plan shall be in the form of insurance and the second plan shall*
11 *be consistent with the requirements of the federal Health Maintenance Organization Act, 42 U.S.C. 300e*
12 *et seq.]]*

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

19 [(b) *The basic health benefit plans shall include benefits mandated under ORS 743A.168 until*
20 *mental health, alcohol and chemical dependency services are fully integrated into the Health Services*
21 *Commission's priority list, and as funded by the Legislative Assembly, and chapter 836, Oregon Laws*
22 *1989, is implemented.]]*

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

25 [(3)] (1) [After the director's approval of the basic health benefit plans submitted by the committee
26 pursuant to subsection (1) of this section, each small employer] **As a condition of transacting busi-**
27 **ness in the small employer health insurance market in this state, a carrier shall offer small**
28 **employers an approved basic health benefit plan and all of the other plans of the carrier that**
29 **have been approved by the Department of Consumer and Business Services for use in the**
30 **small employer market.**

31 (2) A carrier shall submit to the [director] **department, for approval in accordance with ORS**
32 **742.003**, the policy form or forms containing its basic health benefit plan. [Each policy form must be
33 submitted as prescribed by the director and is subject to review and approval pursuant to ORS
34 742.003.]

35 [(4)(a) *As a condition of transacting business in the small employer health insurance market in this*
36 *state, every small employer carrier shall offer small employers an approved basic health benefit plan*
37 *and any other plans that have been submitted by the small employer carrier for use in the small em-*
38 *ployer market and approved by the director.]]*

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

43 [(c)] (3) A carrier that offers a health benefit plan in the small employer market only through
44 one or more bona fide associations is not required to offer that health benefit plan to small em-
45 ployers that are not members of the bona fide association.

1 [(5)] (4) A *[small employer]* carrier shall issue to a small employer any *[small employer]* health
 2 benefit plan, **including a basic health benefit plan, that is** offered by the carrier if the small em-
 3 ployer applies for the plan and agrees to make the required premium payments and to satisfy the
 4 other provisions of the health benefit plan.

5 [(6)] (5) A multiple employer welfare arrangement, professional or trade association or other
 6 similar arrangement established or maintained to provide benefits to a particular trade, business,
 7 profession or industry or their subsidiaries shall not issue coverage to a group or individual that is
 8 not in the same trade, business, profession or industry as that covered by the arrangement. The
 9 arrangement shall accept all groups and individuals in the same trade, business, profession or in-
 10 dustry or their subsidiaries that apply for coverage under the arrangement and that meet the re-
 11 quirements for membership in the arrangement. For purposes of this subsection, the requirements
 12 for membership in an arrangement shall not include any requirements that relate to the actual or
 13 expected health status of the prospective enrollee.

14 [(7)] (6) A *[small employer]* carrier shall, pursuant to *[subsections (4) and (5)]* **subsection (4)** of
 15 this section, *[offer coverage to or accept applications from a]* **accept applications from and offer**
 16 **coverage to a small employer** group covered under an existing *[small employer]* health benefit plan
 17 **regardless of** whether *[or not]* a prospective enrollee is excluded from coverage under the existing
 18 plan because of late enrollment. When a *[small employer]* carrier accepts an application for *[such]*
 19 a **small employer** group, the carrier may continue to exclude the prospective enrollee excluded
 20 from coverage by the replaced plan until the prospective enrollee would have become eligible for
 21 coverage under that replaced plan.

22 [(8)] (7) *[No small employer carrier shall be required to offer coverage or accept applications pur-*
 23 *suant to subsections (4) and (5)]* **A carrier is not required to accept applications from and offer**
 24 **coverage pursuant to subsection (4)** of this section if the *[director]* **department** finds that ac-
 25 ceptance of an application or applications would endanger the carrier's ability to fulfill its con-
 26 tractual obligations or result in financial impairment of the carrier.

27 [(9)] (8) *[Every small employer]* **A** carrier shall market fairly all *[small employer]* health benefit
 28 plans, **including basic health benefit plans, that are** offered by the carrier to small employers in
 29 the geographical areas in which the carrier makes coverage available or provides benefits.

30 [(10)(a)] (9)(a) **Subsection (4) of this section does not require a** *[No small employer]* carrier
 31 *[shall be required]* to offer coverage **to** or accept applications **from** *[pursuant to subsections (4) and*
 32 *(5) of this section in the case of any of the following]:*

33 (A) *[To]* A small employer if the small employer is not physically located in the carrier's ap-
 34 proved service area;

35 (B) *[To]* An employee **of a small employer** if the employee does not work or reside within the
 36 carrier's approved service areas; or

37 (C) **Small employers located** within an area where the carrier reasonably anticipates, and
 38 demonstrates to the *[satisfaction of the director]* **department**, that it will not have the capacity in
 39 its network of providers to deliver services adequately to the enrollees of those **small employer**
 40 groups because of its obligations to existing **small employer** group contract holders and enrollees.

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

44 [(11)] (10) For purposes of ORS 743.733 to 743.737, except as provided in this subsection, carriers
 45 that are affiliated carriers or that are eligible to file a consolidated tax return pursuant to ORS

1 317.715 shall be treated as one carrier and any restrictions or limitations imposed by ORS 743.733
 2 to 743.737 apply as if all health benefit plans delivered or issued for delivery to small employers in
 3 this state by the affiliated carriers were issued by one carrier. However, any insurance company or
 4 health maintenance organization that is an affiliate of a health care service contractor located in
 5 this state, or any health maintenance organization located in this state that is an affiliate of an in-
 6 surance company or health care service contractor, may treat the health maintenance organization
 7 as a separate carrier and each health maintenance organization that operates only one health
 8 maintenance organization in a service area in this state may be considered a separate carrier.

9 [(12)] (11) A [small employer] carrier that[, after September 29, 1991,] elects to discontinue offer-
 10 ing all of its [small employer] health benefit plans **to small employers** under ORS 743.737 [(5)(e)]
 11 **(6)(e)**, elects to discontinue renewing all such plans or elects to discontinue offering and renewing
 12 all such plans is prohibited from offering health benefit plans [in the small employer market] **to small**
 13 **employers** in this state for a period of five years from one of the following dates:

14 (a) The date of notice to the [director] **department** pursuant to ORS 743.737 [(5)(e)] **(6)(e)**; or

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

19 **(12) This section does not require a carrier to actively market, offer, issue or accept ap-**
 20 **lications for a grandfathered health plan or from a small employer not eligible for coverage**
 21 **under such a plan as provided by the Patient Protection and Affordable Care Act (P.L.**
 22 **111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152).**

23 **SECTION 15.** ORS 743.737 is amended to read:

24 743.737. [Health benefit plans covering small employers shall be subject to the following
 25 provisions:]

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

32 (2) A preexisting [conditions provision] **condition exclusion** in a small employer health benefit
 33 plan shall [terminate its effect] **expire** as follows:

34 (a) For an enrollee, [not later than the first of] **on the earlier of** the following dates:

35 (A) Six months [following] **after** the enrollee's effective date of coverage; or

36 (B) Ten months [following] **after** the start of any required group eligibility waiting period.

37 (b) For a late enrollee, not later than 12 months [following] **after** the late enrollee's effective
 38 date of coverage.

39 (3) In applying a preexisting [conditions provision] **condition exclusion** to an enrollee or late
 40 enrollee, except as provided in this subsection, all small employer health benefit plans shall reduce
 41 the duration of the provision by an amount equal to the enrollee's or late enrollee's aggregate pe-
 42 riods of creditable coverage if the most recent period of creditable coverage is ongoing or ended
 43 within 63 days [of] **after** the enrollment date in the new small employer health benefit plan. The
 44 crediting of prior coverage in accordance with this subsection shall be applied without regard to the
 45 specific benefits covered during the prior period. This subsection does not preclude, within a small

1 employer health benefit plan, application of:

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

4 (b) An exclusion period for specified covered services, as established [by the *Health Insurance*
5 *Reform Advisory Committee*] **under ORS 743.745**, applicable to all individuals enrolling for the first
6 time in the small employer health benefit plan.

7 **(4) A health benefit plan issued to a small employer may not apply a preexisting condition**
8 **exclusion to a person under 19 years of age.**

9 [(4)] (5) Late enrollees **in a small employer health benefit plan** may be [excluded from coverage
10 for] **subjected to a group eligibility waiting period of up to 12 months or, if 19 years of age or**
11 **older**, may be subjected to a preexisting [conditions provision] **condition exclusion** for up to 12
12 months. If both [an exclusion from coverage period] **a waiting period** and a preexisting [conditions
13 provision] **condition exclusion** are applicable to a late enrollee, the combined period shall not ex-
14 ceed 12 months.

15 [(5)] (6) Each small employer health benefit plan shall be renewable with respect to all eligible
16 enrollees at the option of the policyholder, small employer or contract holder [except] **unless:**

17 (a) [For nonpayment of the required premiums by] The policyholder, small employer or contract
18 holder **fails to pay the required premiums.**

19 (b) [For fraud or misrepresentation of] The policyholder, small employer or contract holder or,
20 with respect to coverage of individual enrollees, [the enrollees or their representatives] **an enrollee**
21 **or a representative of an enrollee engages in fraud or makes an intentional misrepresen-**
22 **tation of a material fact as prohibited by the terms of the plan.**

23 (c) [When] The number of enrollees covered under the plan is less than the number or percent-
24 age of enrollees required by participation requirements under the plan.

25 (d) [For noncompliance with] The small employer [carrier's employer] **fails to comply with the**
26 **contribution requirements under the health benefit plan.**

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

30 (A) Must give notice of the decision to the [Director of the] Department of Consumer and Busi-
31 ness Services and to all policyholders covered by the plans;

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

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

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

41 (f) [When] The carrier discontinues offering and renewing a small employer health benefit plan
42 in a specified service area within this state because of an inability to reach an agreement with the
43 health care providers or organization of health care providers to provide services under the plan
44 within the service area. In order to discontinue a plan under this paragraph, the carrier:

45 (A) Must give notice to the [director] **department** and to all policyholders covered by the plan;

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

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

7 (g) [When] The carrier discontinues offering or renewing, or offering and renewing, a health
 8 benefit plan, **other than a grandfathered health plan**, for all small employers in this state or in
 9 a specified service area within this state, other than a plan discontinued under paragraph (f) of this
 10 subsection.

11 **(h) The carrier discontinues renewing or offering and renewing a grandfathered health**
 12 **plan for all small employers in this state or in a specified service area within this state, other**
 13 **than a plan discontinued under paragraph (f) of this subsection.**

14 (i) With respect to plans that are being discontinued **under paragraph (g) or (h) of this sub-**
 15 **section**, the carrier must:

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

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

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

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

22 [(h)] (j) [When] The Director **of the Department of Consumer and Business Services** orders
 23 the carrier to discontinue coverage in accordance with procedures specified or approved by the di-
 24 rector upon finding that the continuation of the coverage would:

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

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

27 [(i)] (k) [When,] In the case of a small employer health benefit plan that delivers covered ser-
 28 vices through a specified network of health care providers, there is no longer any enrollee who lives,
 29 resides or works in the service area of the provider network.

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

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

38 [(L)] (7) A [small employer] carrier may modify a small employer health benefit plan at the time
 39 of coverage renewal. The modification is not a discontinuation of the plan under [paragraphs (e) and
 40 (g) of this] subsection **(6)(e), (g) and (h) of this section**.

41 [(6)] (8) Notwithstanding any provision of subsection [(5)] (6) of this section to the contrary, **and**
 42 **subject to the provisions of ORS 743.733 to 743.737 and section 4 (2) and (3) of this 2011 Act,**
 43 **a carrier may rescind** any small employer [carrier] health benefit plan, **or the coverage of an**
 44 **enrollee under a plan**, [subject to the provisions of ORS 743.733 to 743.737 may be rescinded by a
 45 small employer carrier for fraud, material misrepresentation or concealment by a small employer and

1 *the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by*
 2 *the enrollee.] if the small employer, enrollee or representative of a small employer or an*
 3 **enrollee:**

4 **(a) Performs an act, practice or omission that constitutes fraud; or**

5 **(b) Makes an intentional misrepresentation of a material fact as prohibited by the terms**
 6 **of the plan.**

7 [(7)] **(9)** A *[small employer]* carrier may continue to enforce reasonable employer participation
 8 and contribution requirements on small employers applying for coverage. However, participation and
 9 contribution requirements shall be applied uniformly among all small employer groups with the same
 10 number of eligible employees applying for coverage or receiving coverage from the *[small*
 11 *employer]* carrier. In determining minimum participation requirements, a carrier shall count only
 12 those employees who are not covered by an existing group health benefit plan, Medicaid, Medicare,
 13 [CHAMPUS] TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan,
 14 including but not limited to the medical assistance program under ORS chapter 414.

15 [(8)] **(10)** Premium rates for small employer health benefit plans shall be subject to the following
 16 provisions:

17 (a) *[Each small employer carrier issuing health benefit plans to small employers must file its ge-*
 18 *ographic average rate for a rating period with the director at least once every 12 months.] Each car-*
 19 **rier must file with the department the initial geographic average rate and any changes in the**
 20 **geographic average rate with respect to each health benefit plan issued by the carrier to**
 21 **small employers.**

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

25 (B) The variations in premium rates described in subparagraph (A) of this paragraph shall be
 26 based solely on the factors specified in subparagraph (C) of this paragraph. A *[small employer]* car-
 27 rier may elect which of the factors specified in subparagraph (C) of this paragraph apply to premium
 28 rates for **health benefit plans for** small employers. The factors that are based on contributions or
 29 participation may vary with the size of the employer. All other factors must be applied in the same
 30 actuarially sound way to all small *[employers]* **employer health benefit plans.**

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

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

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

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

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

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

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

42 (vii) Adjustments to reflect the provision of benefits not required to be covered by the basic
 43 health benefit plan and differences in family composition.

44 (D)(i) The premium rates determined in accordance with this paragraph may be further adjusted
 45 by a *[small employer]* carrier to reflect the expected claims experience of [a] **the covered** small

1 employer, but the extent of this adjustment may not exceed five percent of the annual premium rate
 2 otherwise payable by the small employer. The adjustment under this subparagraph may not be cu-
 3 mulative from year to year.

4 (ii) [Except for small employers with 25 or fewer employees,] The premium rates adjusted under
 5 this subparagraph, **except rates for small employers with 25 or fewer employees**, are not subject
 6 to the provisions of subparagraph (A) of this paragraph.

7 (E) A [small employer] carrier shall apply the carrier's schedule of premium rate variations as
 8 approved by [the Director of] the department [of Consumer and Business Services] and in accordance
 9 with this paragraph. Except as otherwise provided in this section, the premium rate established by
 10 a carrier for a **small employer** health benefit plan [by a small employer carrier] shall apply uni-
 11 formly to all employees of the small employer enrolled in that plan.

12 (c) Except as provided in paragraph (b) of this subsection, the variation in premium rates be-
 13 tween different [small employer] health benefit plans offered by a [small employer] carrier to **small**
 14 **employers** must be based solely on objective differences in plan design or coverage and must not
 15 include differences based on the risk characteristics of groups assumed to select a particular health
 16 benefit plan.

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

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

24 (B) Any adjustment attributable to changes in age, except an additional adjustment may be made
 25 to reflect the provision of benefits not required to be covered by the basic health benefit plan and
 26 differences in family composition.

27 (e) Premium rates for **small employer** health benefit plans shall comply with the requirements
 28 of this section.

29 [(9)] (11) In connection with the offering for sale of any health benefit plan to a small employer,
 30 each [small employer] carrier shall make a reasonable disclosure as part of its solicitation and sales
 31 materials of:

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

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

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

36 (d) Provisions affecting any preexisting [conditions provision] **condition exclusion**.

37 [(10)(a)] (12)(a) Each [small employer] carrier shall maintain at its principal place of business a
 38 complete and detailed description of its rating practices and renewal underwriting practices **relat-**
 39 **ing to its small employer health benefit plans**, including information and documentation that
 40 demonstrate that its rating methods and practices are based upon commonly accepted actuarial
 41 practices and are in accordance with sound actuarial principles.

42 (b) [Each small employer] A carrier **offering a small employer health benefit plan** shall file
 43 with the [director] **department** at least once every 12 months an actuarial certification that the
 44 carrier is in compliance with ORS 743.733 to 743.737 and that the rating methods of the [small em-
 45 ployer] carrier are actuarially sound. Each [such] certification shall be in a uniform form and manner

1 and shall contain such information as specified by the [*director*] **department**. A copy of [*such*] **each**
 2 certification shall be retained by the [*small employer*] carrier at its principal place of business.

3 (c) A [*small employer*] carrier shall make the information and documentation described in para-
 4 graph (a) of this subsection available to the [*director*] **department** upon request. Except as provided
 5 in ORS 743.018 and except in cases of violations of ORS 743.733 to 743.737, the information shall
 6 be considered proprietary and trade secret information and shall not be subject to disclosure [*by the*
 7 *director*] to persons outside the department [*of Consumer and Business Services*] except as agreed to
 8 by the [*small employer*] carrier or as ordered by a court of competent jurisdiction.

9 [(11)] (13) A [*small employer*] carrier shall not provide any financial or other incentive to any
 10 insurance producer that would encourage the insurance producer to market and sell health benefit
 11 plans of the carrier to small employer groups based on a small employer group's anticipated claims
 12 experience.

13 [(12)] (14) For purposes of this section, the date a small employer health benefit plan is contin-
 14 ued shall be the anniversary date of the first issuance of the health benefit plan.

15 [(13)] (15) A [*small employer*] carrier must include a provision that offers coverage to all eligible
 16 employees **of a small employer** and to all dependents **of the eligible employees** to the extent the
 17 employer chooses to offer coverage to dependents.

18 [(14)] (16) All small employer health benefit plans shall contain special enrollment periods dur-
 19 ing which eligible employees and dependents may enroll for coverage, as provided in 42 U.S.C.
 20 300gg as amended and in effect on [*July 1, 1997*] **February 17, 2009**.

21 (17) **A small employer health benefit plan may not impose annual or lifetime dollar limits**
 22 **on the essential health benefits prescribed by the United States Secretary of Health and**
 23 **Human Services pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law.**

24 (18) **This section does not require a carrier to actively market, offer, issue or accept ap-**
 25 **plications for a grandfathered health plan or from a small employer not eligible for coverage**
 26 **under such a plan as provided by the Patient Protection and Affordable Care Act (P.L.**
 27 **111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152).**

28 **SECTION 16.** ORS 743.745 is amended to read:

29 743.745. (1) The Director of the Department of Consumer and Business Services shall [*appoint*
 30 *a Health Insurance Reform Advisory Committee. This committee shall consist of at least one insurance*
 31 *producer, one representative of a health maintenance organization, one representative of a health care*
 32 *service contractor, one representative of a domestic insurer, one representative of a labor organization*
 33 *and one representative of consumer interests and shall have representation from the broad range of*
 34 *interests involved in the small employer and individual market and shall include members with the*
 35 *technical expertise necessary to carry out the following duties:]*

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

43 [(A)] (a) Preferred provider provisions;

44 [(B)] (b) Utilization review of health care services including review of medical necessity of
 45 hospital and physician services;

1 [(C)] (c) Case management benefit alternatives;

2 [(D)] (d) Other managed care provisions;

3 [(E)] (e) Selective contracting with hospitals, physicians and other health care providers; and

4 [(F)] (f) Reasonable benefit differentials applicable to participating and nonparticipating provid-
5 ers.

6 [(b) *The committee shall submit the basic and portability health benefit plans and other recom-*
7 *mendations to the director within the time period established by the director. The health benefit plans*
8 *and other recommendations shall be deemed approved unless expressly disapproved by the director*
9 *within 30 days after the date the director receives the plans.*]

10 (2) In order to ensure the broadest availability of small employer, **portability** and individual
11 health benefit plans, [*the committee shall recommend for approval by*] the director **may approve**
12 market conduct and other requirements for carriers and insurance producers, including [*require-*
13 *ments developed as a result of a request by the director, relating to the following*]:

14 (a) Registration by each carrier with the Department of Consumer and Business Services of
15 [*its*] **the carrier's** intention to [*be a small employer carrier*] **offer group health benefit plans** under
16 ORS 743.733 to 743.737 or [*a carrier offering*] individual health benefit plans, or both.

17 [(b) *Publication by the department of Consumer and Business Services or the committee of a list*
18 *of all small employer carriers and carriers offering individual health benefit plans, including a poten-*
19 *tial requirement applicable to insurance producers and carriers that no health benefit plan be sold to*
20 *a small employer or individual by a carrier not so identified as a small employer carrier or carrier*
21 *offering individual health benefit plans.*]

22 [(c)] (b) To the extent deemed necessary by the [*committee*] **director** to ensure the fair distrib-
23 ution of high-risk individuals and groups among carriers, periodic reports by carriers and insurance
24 producers concerning small employer, portability and individual health benefit plans issued, provided
25 that reporting requirements shall be limited to information concerning case characteristics and
26 numbers of health benefit plans in various categories marketed or issued[, *or both,*] to small em-
27 ployers and individuals.

28 [(d)] (c) Methods concerning periodic demonstration by [*small employer carriers,*] carriers offer-
29 ing [*individual*] health benefit plans **to individuals or small employers** and insurance producers
30 that the [*small employer and individual*] carriers **and insurance producers** are marketing or
31 issuing[, *or both,*] health benefit plans [*to small employers or individuals*] in fulfillment of the pur-
32 poses of ORS 743.730 to 743.773.

33 (3) [*Subject to the approval of the director of the Department of Consumer and Business Services,*
34 *the committee*] **The director** shall develop a standard health statement to be used for all late
35 enrollees and by all carriers offering individual policies of health insurance.

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

40 **SECTION 17.** ORS 743.748 is amended to read:

41 743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the De-
42 partment of Consumer and Business Services on or before April 1 of each year a report that con-
43 tains:

44 (a) The following information for the preceding year that is derived from the exhibit of premi-
45 ums, enrollment and utilization included in the carrier's annual report:

- 1 (A) The total number of members;
- 2 (B) The total amount of premiums;
- 3 (C) The total amount of costs for claims;
- 4 (D) The medical loss ratio;
- 5 (E) The average amount of premiums per member per month; and
- 6 (F) The percentage change in the average premium per member per month, measured from the
- 7 previous year.

8 (b) The following aggregate financial information for the preceding year that is derived from the

9 carrier's annual report:

10 (A) The total amount of general administrative expenses, including identification of the five

11 largest nonmedical administrative expenses and the assessment against the carrier for the Oregon

12 Medical Insurance Pool;

- 13 (B) The total amount of the surplus maintained;
- 14 (C) The total amount of the reserves maintained for unpaid claims;
- 15 (D) The total net underwriting gain or loss; and
- 16 (E) The carrier's net income after taxes.

17 (c) The retention rate and claims experience of employer groups within the plan for the pre-

18 ceding year for association health plans as described in ORS 743.734 (7). This information is not

19 subject to public disclosure under ORS chapter 192.

20 (2) A carrier shall electronically submit the information described in subsection (1) of this sec-

21 tion in a format and according to instructions prescribed by the Department of Consumer and

22 Business Services by rule *[after obtaining a recommendation from the Health Insurance Reform Ad-*

23 *visory Committee]*.

24 (3) The *[advisory committee]* **department** shall evaluate the reporting requirements under sub-

25 section (1)(a) of this section by the following market segments:

- 26 (a) Individual health benefit plans;
- 27 (b) Health benefit plans for small employers;
- 28 (c) Health benefit plans for employers described in ORS 743.733;
- 29 (d) Health benefit plans for employers with more than 50 employees; and
- 30 (e) Association health plans described in ORS 743.734 (7).

31 (4) The department shall make the information reported under this section available to the

32 public through a searchable public website on the Internet.

33 **SECTION 18.** ORS 743.748, as amended by section 10, chapter 752, Oregon Laws 2007, is

34 amended to read:

35 743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the De-

36 partment of Consumer and Business Services on or before April 1 of each year a report that con-

37 tains:

38 (a) The following information for the preceding year that is derived from the exhibit of premi-

39 ums, enrollment and utilization included in the carrier's annual report:

- 40 (A) The total number of members;
- 41 (B) The total amount of premiums;
- 42 (C) The total amount of costs for claims;
- 43 (D) The medical loss ratio;
- 44 (E) The average amount of premiums per member per month; and
- 45 (F) The percentage change in the average premium per member per month, measured from the

1 previous year.

2 (b) The following aggregate financial information for the preceding year that is derived from the
3 carrier's annual report:

4 (A) The total amount of general administrative expenses, including identification of the five
5 largest nonmedical administrative expenses and the assessment against the carrier for the Oregon
6 Medical Insurance Pool;

7 (B) The total amount of the surplus maintained;

8 (C) The total amount of the reserves maintained for unpaid claims;

9 (D) The total net underwriting gain or loss; and

10 (E) The carrier's net income after taxes.

11 (2) A carrier shall electronically submit the information described in subsection (1) of this sec-
12 tion in a format and according to instructions prescribed by the Department of Consumer and
13 Business Services by rule *[after obtaining a recommendation from the Health Insurance Reform Ad-
14 visory Committee]*.

15 (3) The *[advisory committee]* **department** shall evaluate the reporting requirements under sub-
16 section (1)(a) of this section by the following market segments:

17 (a) Individual health benefit plans;

18 (b) Health benefit plans for small employers;

19 (c) Health benefit plans for employers described in ORS 743.733; and

20 (d) Health benefit plans for employers with more than 50 employees.

21 (4) The department shall make the information reported under this section available to the
22 public through a searchable public website on the Internet.

23 **SECTION 19.** ORS 743.751 is amended to read:

24 743.751. (1) Except to determine the application of a preexisting *[conditions provision]* **condition**
25 **exclusion** for a late enrollee **who is 19 years of age or older or as prescribed by the Depart-**
26 **ment of Consumer and Business Services by rule**, a carrier offering group health benefit plans
27 shall not use health statements when offering such plans to a group of two or more prospective
28 certificate holders and shall not use any other method to determine the actual or expected health
29 status of eligible prospective enrollees. Nothing in this section shall prevent a carrier from using
30 health statements or other information after enrollment for the purpose of providing services or
31 arranging for the provision of services under a health benefit plan or from obtaining aggregate
32 group information related to historical medical claims expenses and health behavior surveys for
33 rating purposes.

34 (2) Subsection (1) of this section applies only to group health benefit plans that are not small
35 employer health benefit plans.

36 **SECTION 20.** ORS 743.754 is amended to read:

37 743.754. The following requirements apply to all group health benefit plans **other than small**
38 **employer health benefit plans** covering two or more certificate holders:

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

45 (2) A preexisting *[conditions provision in a group health benefit plan]* **condition exclusion may**

1 **not apply to a person under 19 years of age and** shall *[terminate its effect]* **expire** as follows:

2 (a) For an enrollee, **on the earlier of** *[not later than the first of]* the following dates:

3 (A) Six months *[following]* **after** the enrollee's effective date of coverage; or

4 (B) Twelve months *[following]* **after** the start of any required group eligibility waiting period.

5 (b) For a late enrollee, not later than 12 months *[following]* **after** the late enrollee's effective
6 date of coverage.

7 (3) In applying a preexisting *[conditions provision]* **condition exclusion** to an enrollee or late
8 enrollee **who is 19 years of age or older**, except as provided in this subsection, all *[group benefit]*
9 plans shall reduce the duration of the provision by an amount equal to the enrollee's or late
10 enrollee's aggregate periods of creditable coverage if the most recent period of creditable coverage
11 is ongoing or ended within 63 days *[of]* **after** the enrollment date in the new *[group health benefit]*
12 plan. The crediting of prior coverage in accordance with this subsection shall be applied without
13 regard to the specific benefits covered during the prior period. This subsection does not preclude,
14 within a *[group health benefit]* plan, application of:

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

17 (b) An exclusion period for specified covered services applicable to all individuals enrolling for
18 the first time in the *[group health benefit]* plan.

19 (4) Late enrollees may be *[excluded from coverage for]* **subjected to a group eligibility waiting**
20 **period of** up to 12 months or, **if 19 years of age or older**, may be subjected to a preexisting *[con-*
21 *ditions provision]* **condition exclusion** for up to 12 months. If both *[an exclusion from coverage*
22 *period]* **a waiting period** and a preexisting *[conditions provision]* **condition exclusion** are applicable
23 to a late enrollee, the combined period shall not exceed 12 months.

24 (5) *[All group health benefit plans shall contain special enrollment periods]* **Each plan shall**
25 **contain a special enrollment period** during which eligible employees and dependents may enroll
26 for coverage, as provided in 42 U.S.C. 300gg as amended and in effect on *[July 1, 1997]* **February**
27 **17, 2009.**

28 (6) Each *[group health benefit]* plan shall be renewable with respect to all eligible enrollees at
29 the option of the policyholder *[except]* **unless:**

30 (a) *[For nonpayment of]* **The policyholder fails to pay** the required premiums *[by the*
31 *policyholder]*.

32 (b) *[For fraud or misrepresentation of]* The policyholder or, with respect to coverage of individual
33 enrollees, *[the enrollees or their representatives]* **an enrollee or a representative of an enrollee**
34 **engages in fraud or makes an intentional misrepresentation of a material fact as prohibited**
35 **by the terms of the plan.**

36 (c) *[When]* The number of enrollees covered under the plan is less than the number or percent-
37 age of enrollees required by participation requirements under the plan.

38 (d) *[For noncompliance with the carrier's employer]* **The policyholder fails to comply with the**
39 contribution requirements under the *[health benefit]* plan.

40 (e) *[When]* The carrier discontinues offering or renewing, or offering and renewing, all of its
41 group *[health benefit]* plans in this state or in a specified service area within this state. In order to
42 discontinue plans under this paragraph, the carrier:

43 (A) Must give notice of the decision to *[the Director of]* the Department of Consumer and Busi-
44 ness Services and to all policyholders covered by the plans;

45 (B) May not cancel coverage under the plans for 180 days after the date of the notice required

1 under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except
2 as provided in subparagraph (C) of this paragraph, in a specified service area;

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

7 (D) Must discontinue offering or renewing, or offering and renewing, all [*health benefit*] plans
8 issued by the carrier in the group market in this state or in the specified service area.

9 (f) [*When*] The carrier discontinues offering and renewing a group [*health benefit*] plan in a
10 specified service area within this state because of an inability to reach an agreement with the health
11 care providers or organization of health care providers to provide services under the plan within the
12 service area. In order to discontinue a plan under this paragraph, the carrier:

13 (A) Must give notice of the decision to the [*director*] **department** and to all policyholders cov-
14 ered by the plan;

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

17 (C) Must offer in writing to each policyholder covered by the plan, all other group health benefit
18 plans that the carrier offers in the specified service area. The carrier shall offer the plans at least
19 90 days prior to discontinuation.

20 (g) [*When*] The carrier discontinues offering or renewing, or offering and renewing, a health
21 benefit plan, **other than a grandfathered health plan**, for all groups in this state or in a specified
22 service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

23 **(h) The carrier discontinues renewing or offering and renewing a grandfathered health**
24 **plan for all groups in this state or in a specified service area within this state, other than a**
25 **plan discontinued under paragraph (f) of this subsection.**

26 (i) With respect to plans that are being discontinued **under paragraph (g) or (h) of this sub-**
27 **section**, the carrier must:

28 (A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans
29 that the carrier offers in the specified service area.

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

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

33 [*h*] (j) [*When*] The Director **of the Department of Consumer and Business Services** orders
34 the carrier to discontinue coverage in accordance with procedures specified or approved by the di-
35 rector upon finding that the continuation of the coverage would:

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

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

38 [*i*] (k) [*When,*] In the case of a [*group health benefit*] plan that delivers covered services
39 through a specified network of health care providers, there is no longer any enrollee who lives, re-
40 sides or works in the service area of the provider network.

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

44 [*k*] *For misuse of a provider network provision. As used in this paragraph, "misuse of a provider*
45 *network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the*

1 *physical health or well-being of health care staff and seriously impairs the ability of the carrier or its*
 2 *participating providers to provide services to an enrollee. An enrollee under this paragraph retains the*
 3 *rights of an enrollee under ORS 743.804.]*

4 [(L)] (7) A carrier may modify a [group health benefit] plan at the time of coverage renewal. The
 5 modification is not a discontinuation of the plan under [paragraphs (e) and (g) of this] subsection
 6 **(6)(e), (g) and (h) of this section.**

7 [(7)] (8) Notwithstanding any provision of subsection (6) of this section to the contrary, **and**
 8 **subject to the provisions of section 4 (2) and (3) of this 2011 Act, a carrier may rescind a**
 9 **[group health benefit] plan, or the coverage of an enrollee under a plan,** [may be rescinded by a
 10 carrier for fraud, material misrepresentation or concealment by a policyholder and the coverage of an
 11 enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.] **if the**
 12 **policyholder, enrollee or representative of a policyholder or enrollee:**

13 **(a) Performs an act, practice or omission that constitutes fraud; or**

14 **(b) Makes an intentional misrepresentation of a material fact as prohibited by the terms**
 15 **of the plan.**

16 [(8)] (9) A carrier that continues to offer coverage in the group market in this state is not re-
 17 quired to offer coverage in all of the carrier's group [health benefit] plans. If a carrier, however,
 18 elects to continue a plan that is closed to new policyholders instead of offering alternative coverage
 19 in its other group [health benefit] plans, the coverage for all existing policyholders in the closed plan
 20 is renewable in accordance with subsection (6) of this section.

21 [(9) This section applies only to group health benefit plans that are not small employer health
 22 benefit plans.]

23 **(10) A group health benefit plan may not impose annual or lifetime dollar limits on the**
 24 **essential health benefits prescribed by the United States Secretary of Health and Human**
 25 **Services pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law.**

26 **(11) This section does not require a carrier to actively market, offer, issue or accept ap-**
 27 **plications for a grandfathered health plan or from a group not eligible for coverage under**
 28 **such a plan as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as**
 29 **amended by the Health Care and Education Reconciliation Act (P.L. 111-152).**

30 **SECTION 21.** ORS 743.758 is amended to read:

31 743.758. The Department of Consumer and Business Services may adopt rules incorporating,
 32 implementing and administering the Health Insurance Portability and Accountability Act of 1996
 33 (P.L. 104-191), **the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by**
 34 **the Health Care and Education Reconciliation Act (P.L. 111-152)** and federal regulations that
 35 are issued in conjunction with the [Act] **Acts** [, to the extent that such federal law and regulations
 36 are not inconsistent with any provision of Oregon law].

37 **SECTION 22.** ORS 743.760 is amended to read:

38 743.760. (1) As used in this section:

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

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

42 (i) Has left coverage that was continuously in effect for a period of 180 days or more under one
 43 or more Oregon group health benefit plans, has applied for portability coverage not later than the
 44 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident
 45 at the time of such application; or

1 (ii) [*On or after January 1, 1998,*] Meets the eligibility requirements of 42 U.S.C. 300gg-41, [*as*
2 *amended and in effect on January 1, 1998,*] has applied for portability coverage not later than the
3 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident
4 at the time of such application.

5 (B) Except as provided in subsection (12) of this section, “eligible individual” does not include
6 an individual who remains eligible for the individual’s prior group coverage or would remain eligible
7 for prior group coverage in a plan under the federal Employee Retirement Income Security Act of
8 1974, as amended, were it not for action by the plan sponsor relating to the actual or expected
9 health condition of the individual, or who is covered under another health benefit plan at the time
10 that portability coverage would commence or is eligible for the federal Medicare program.

11 (c) “Portability health benefit plans” and “portability plans” mean health benefit plans for eli-
12 gible individuals that are required to be offered by all carriers offering group health benefit plans
13 and that have been approved by the Director of the Department of Consumer and Business Services
14 in accordance with this section.

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

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

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

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

27 (3) The [*director shall approve the*] **standards for** portability health benefit plans [*if*] **established**
28 **by** the director **under subsection (2) of this section must** [*determines that the plans*] provide for
29 appropriate accessibility and affordability of needed health care services and comply with all other
30 provisions of this section.

31 (4) [*After the director’s approval of the portability plans submitted by the committee under this*
32 *section,*] Each carrier offering group health benefit plans shall submit to the director the policy form
33 or forms containing at least one low cost benefit and one prevailing benefit portability plan offered
34 by the carrier that meets the [*required*] standards **established by the director under subsection**
35 **(2) of this section.** Each policy form must be submitted as prescribed by the director and is subject
36 to review and approval pursuant to ORS 742.003.

37 (5) [*Within*] **No later than** 180 days after [*approval by*] the director [*of the*] **establishes stan-**
38 **dards for** portability plans [*submitted by the committee*], as a condition of transacting group health
39 insurance in this state, each carrier offering group health benefit plans shall make available to eli-
40 gible individuals the prevailing benefit and low cost benefit portability plans that have been sub-
41 mitted by the carrier and approved by the director under subsection (4) of this section.

42 (6) A carrier offering group health benefit plans shall issue to an eligible individual who is
43 leaving or has left group coverage provided by that carrier any portability plan offered by the car-
44 rier if the eligible individual applies for the plan within 63 days [*of*] **after** termination of prior cov-
45 erage and agrees to make the required premium payments and to satisfy the other provisions of the

1 portability plan.

2 (7) Premium rates for portability plans shall be subject to the following provisions:

3 (a) Each carrier must file *[the geographic average rate for each of its portability health benefit*
4 *plans for a rating period]* with the director *[on or before March 15 of each year]* **the carrier's initial**
5 **geographic average rate and any changes in the geographic average rate with respect to each**
6 **portability health benefit plan issued by the carrier.**

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

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

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

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

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

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

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

31 (8) *[No]* **A** portability *[plans]* **plan** under this section may **not** contain preexisting *[conditions*
32 *provisions, exclusion periods]* **condition exclusions**, waiting periods or other similar limitations on
33 coverage.

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

36 (a) *[For nonpayment of the required premiums by]* The policyholder **fails to pay the required**
37 **premiums**;

38 (b) *[For fraud or misrepresentation by]* The policyholder **or a representative of the**
39 **policyholder engages in fraud or makes an intentional misrepresentation of a material fact**
40 **as prohibited by the terms of the policy**;

41 (c) *[When]* The carrier elects to discontinue offering all of its group health benefit plans in ac-
42 cordance with ORS 743.737 and 743.754; or

43 (d) *[When]* The director orders the carrier to discontinue coverage in accordance with proce-
44 dures specified or approved by the director upon finding that the continuation of the coverage
45 would:

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

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

3 (10)(a) *[Each]* A carrier offering a group health benefit *[plans]* **plan** shall maintain at its princi-
4 pal place of business a complete and detailed description of its rating practices and renewal under-
5 writing practices relating to its portability plans, including information and documentation that
6 demonstrate that its rating methods and practices are based upon commonly accepted actuarial
7 practices and are in accordance with sound actuarial principles.

8 (b) *[Each such]* A carrier **offering a group health benefit plan** shall file with the *[director]*
9 **Department of Consumer and Business Services** annually on or before March 15 an actuarial
10 certification that the carrier is in compliance with this section and that its rating methods are
11 actuarially sound. Each *[such]* certification shall be in a form and manner and shall contain such
12 information as specified by the *[director]* **department**. A copy of *[such]* **each** certification shall be
13 retained by the carrier at its principal place of business.

14 (c) *[Each such]* A carrier **offering a group health benefit plan** shall make the information and
15 documentation described in paragraph (a) of this subsection available to the *[director]* **department**
16 upon request. Except as provided in ORS 743.018 and except in cases of violations of the Insurance
17 Code, the information is proprietary and trade secret information and shall not be subject to dis-
18 closure *[by the director]* to persons outside the department *[of Consumer and Business Services]* ex-
19 cept as agreed to by the carrier or as ordered by a court of competent jurisdiction.

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

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

29 **(13) Subject to the provisions of section 4 (2) and (3) of this 2011 Act, a carrier may**
30 **rescind a portability health benefit plan issued to a policyholder only if the policyholder or**
31 **a representative of the policyholder:**

32 (a) **Performs an act, practice or omission that constitutes fraud; or**

33 (b) **Makes an intentional misrepresentation of a material fact as prohibited by the terms**
34 **of the policy.**

35 **SECTION 23.** ORS 743.761 is amended to read:

36 743.761. (1) A carrier approved pursuant to subsection (4) of this section that offers individual
37 health benefit plans may satisfy the requirements of ORS 743.760 by issuing any individual health
38 benefit plan offered by the carrier to any eligible individual as defined in ORS 743.760 who:

39 (a) Is leaving or has left a group health benefit plan provided by that carrier;

40 (b) Applies for the policy; and

41 (c) Agrees to make the required premium payments and to satisfy the other provisions of the
42 plan.

43 (2) All health benefit plans issued pursuant to subsection (1) of this section shall:

44 (a) Comply with ORS 743.767 and 743.769; and

45 (b) Contain no preexisting *[conditions provisions, exclusion periods]* **condition exclusions**, wait-

1 ing periods or other similar limitations on coverage.

2 (3) A carrier offering plans pursuant to this section shall offer plans that meet the standards
3 and requirements described in ORS 743.760 (2).

4 (4) The Director of the Department of Consumer and Business Services shall adopt standards for
5 minimum participation in the individual market necessary for a carrier to offer policies under this
6 section and shall develop a program for approval of carriers under this section.

7 **SECTION 24.** ORS 743.766 is amended to read:

8 743.766. (1) All carriers *[who]* **that** offer **an** individual health benefit *[plans]* **plan** and evaluate
9 the health status of individuals for purposes of eligibility shall use the standard health statement
10 established *[by the Health Insurance Reform Advisory Committee]* **under ORS 743.745** and may not
11 use any other method to determine the health status of an individual. Nothing in this subsection
12 shall prevent a carrier from using health information after enrollment for the purpose of providing
13 services or arranging for the provision of services under a health benefit plan.

14 (2)(a) If an individual is accepted for coverage under an individual health benefit plan, the car-
15 rier shall not impose exclusions or limitations *[on coverage greater]* **other** than:

16 (A) A preexisting *[conditions provision]* **condition exclusion** that complies with the following
17 requirements:

18 (i) The *[provision shall apply]* **exclusion applies** only to a condition for which medical advice,
19 diagnosis, care or treatment was recommended or received during the six-month period immediately
20 preceding the individual's effective date of coverage; *[and]*

21 (ii) The *[provision shall terminate its effect]* **exclusion expires** no later than six months
22 *[following]* **after** the individual's effective date of coverage; **and**

23 **(iii) Except for grandfathered health plans, the exclusion does not apply to individuals**
24 **who are under 19 years of age;**

25 (B) An individual coverage waiting period of 90 days; or

26 (C) An exclusion period for specified covered services applicable to all individuals enrolling for
27 the first time in the individual health benefit plan.

28 (b) **Except for grandfathered health plans, pregnancy of individuals who are under 19 years**
29 **of age may not** constitute a preexisting condition for purposes of this section.

30 (3) If the carrier elects to restrict coverage through the application of a preexisting *[conditions*
31 *provision]* **condition exclusion** or an individual coverage waiting period provision, the carrier shall
32 reduce the duration of the provision by an amount equal to the individual's aggregate periods of
33 creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63
34 days *[of]* **after** the effective date of coverage in the new individual health benefit plan. The crediting
35 of prior coverage in accordance with this subsection shall be applied without regard to the specific
36 benefits covered during the prior period.

37 (4) If an eligible prospective enrollee is rejected for coverage under an individual health benefit
38 plan, the prospective enrollee shall be eligible to apply for coverage under the Oregon Medical In-
39 surance Pool.

40 (5) If a carrier accepts an individual for coverage under an individual health benefit plan, the
41 carrier shall renew the policy *[except]* **unless**:

42 (a) *[For nonpayment of the required premiums by]* The policyholder **fails to pay the required**
43 **premiums.**

44 (b) *[For fraud or misrepresentation by]* The policyholder **or a representative of the**
45 **policyholder engages in fraud or makes an intentional misrepresentation of a material fact**

1 **as prohibited by the terms of the policy.**

2 (c) [*When*] The carrier discontinues offering or renewing, or offering and renewing, all of its
3 individual health benefit plans in this state or in a specified service area within this state. In order
4 to discontinue the plans under this paragraph, the carrier:

5 (A) Must give notice of the decision to the [*Director of the*] Department of Consumer and Busi-
6 ness Services and to all policyholders covered by the plans;

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

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

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

16 (d) [*When*] The carrier discontinues offering and renewing an individual health benefit plan in
17 a specified service area within this state because of an inability to reach an agreement with the
18 health care providers or organization of health care providers to provide services under the plan
19 within the service area. In order to discontinue a plan under this paragraph, the carrier:

20 (A) Must give notice of the decision to the [*director*] **department** and to all policyholders cov-
21 ered by the plan;

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

24 (C) Must offer in writing to each policyholder covered by the plan, all other individual health
25 benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans
26 at least 90 days prior to discontinuation.

27 (e) [*When*] The carrier discontinues offering or renewing, or offering and renewing, an individual
28 health benefit plan, **other than a grandfathered health plan**, for all individuals in this state or in
29 a specified service area within this state, other than a plan discontinued under paragraph (d) of this
30 subsection.

31 **(f) The carrier discontinues renewing or offering and renewing a grandfathered health**
32 **plan for all individuals in this state or in a specified service area within this state, other than**
33 **a plan discontinued under paragraph (d) of this subsection.**

34 **(g) With respect to plans that are being discontinued under paragraph (e) or (f) of this sub-**
35 **section**, the carrier must:

36 (A) Offer in writing to each policyholder covered by the plan, one or more individual health
37 benefit plans that the carrier offers **to individuals** in the specified service area.

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

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

41 [*f*] **(h) [*When*] The Director of the Department of Consumer and Business Services orders**
42 **the carrier to discontinue coverage in accordance with procedures specified or approved by the di-**
43 **rector upon finding that the continuation of the coverage would:**

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

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

1 [(g)] (i) [When,] In the case of an individual health benefit plan that delivers covered services
 2 through a specified network of health care providers, the enrollee no longer lives, resides or works
 3 in the service area of the provider network and the termination of coverage is not related to the
 4 health status of any enrollee.

5 [(h)] (j) [When,] In the case of a health benefit plan that is offered in the individual market only
 6 through one or more bona fide associations, the membership of an individual in the association
 7 ceases and the termination of coverage is not related to the health status of any enrollee.

8 [(i) For misuse of a provider network provision. As used in this paragraph, “misuse of a provider
 9 network provision” means a disruptive, unruly or abusive action taken by an enrollee that threatens the
 10 physical health or well-being of health care staff and seriously impairs the ability of the carrier or its
 11 participating providers to provide service to an enrollee. An enrollee under this paragraph retains the
 12 rights of an enrollee under ORS 743.804.]

13 [(j)] (6) A carrier may modify an individual health benefit plan at the time of coverage renewal.
 14 The modification is not a discontinuation of the plan under [paragraphs (c) and (e) of this] subsection
 15 **(5)(c), (e) and (f) of this section.**

16 [(6)] (7) Notwithstanding any other provision of this section, **and subject to the provisions of**
 17 **section 4 (2) and (3) of this 2011 Act**, a carrier may rescind an individual health benefit plan [for
 18 fraud, material misrepresentation or concealment by an enrollee.] **if the policyholder or a represen-**
 19 **tative of the policyholder:**

20 (a) **Performs an act, practice or omission that constitutes fraud; or**

21 (b) **Makes an intentional misrepresentation of a material fact as prohibited by the terms**
 22 **of the policy.**

23 [(7)] (8) A carrier that withdraws from the market for individual health benefit plans must con-
 24 tinue to renew its portability health benefit plans that have been approved pursuant to ORS 743.761.

25 [(8)] (9) A carrier that continues to offer coverage in the individual market in this state is not
 26 required to offer coverage in all of the carrier’s individual health benefit plans. However, if a carrier
 27 elects to continue a plan that is closed to new individual policyholders instead of offering alterna-
 28 tive coverage in its other individual health benefit plans, the coverage for all existing policyholders
 29 in the closed plan is renewable in accordance with subsection (5) of this section.

30 (10) **An individual health benefit plan may not impose lifetime dollar limits on the es-**
 31 **sential health benefits prescribed by the United States Secretary of Health and Human Ser-**
 32 **VICES pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law.**

33 (11) **This section does not require a carrier to actively market, offer, issue or accept ap-**
 34 **plications for a grandfathered health plan or from an individual not eligible for coverage**
 35 **under such a plan as provided by the Patient Protection and Affordable Care Act (P.L.**
 36 **111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152).**

37 **SECTION 25.** ORS 743.767 is amended to read:

38 743.767. Premium rates for individual health benefit plans shall be subject to the following pro-
 39 visions:

40 (1) Each carrier must file the **carrier’s initial** geographic average rate **and any changes to**
 41 **the geographic average rate** for its individual health benefit plans [for a rating period] with the
 42 Director of the Department of Consumer and Business Services [on or before March 15 of each
 43 year].

44 (2) The premium rates charged during a rating period for individual health benefit plans issued
 45 to individuals shall not vary from the individual geographic average rate, except that the premium

1 rate may be adjusted to reflect differences in benefit design, family composition and age. For age
2 adjustments to the individual plans, a carrier shall apply uniformly its schedule of age adjustments
3 for individual health benefit plans as approved by the director.

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

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

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

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

22 **SECTION 26.** ORS 743.801 is amended to read:

23 743.801. As used in **this section and** ORS [743.801,] 743.803, 743.804, 743.806, 743.807, 743.808,
24 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839,
25 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.912, 743.913,
26 743.917[,] **and** 743.918 [and 743A.012] **and section 4 of this 2011 Act:**

27 (1) **"Adverse benefit determination" means an insurer's denial, reduction or termination**
28 **of a health care item or service, or an insurer's failure or refusal to provide or to make a**
29 **payment in whole or in part for a health care item or service, that is based on the insurer's:**

30 (a) **Denial or termination of enrollment of an individual in a health benefit plan;**

31 (b) **Rescission or cancellation of a policy or certificate;**

32 (c) **Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-**
33 **injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise**
34 **covered items or services;**

35 (d) **Determination that a health care item or service is experimental, investigational or**
36 **not medically necessary, effective or appropriate; or**

37 (e) **Determination that a course or plan of treatment that an enrollee is undergoing is**
38 **an active course of treatment for purposes of continuity of care under ORS 743.854.**

39 (2) **"Authorized representative" means an individual who by law or by the consent of a**
40 **person may act on behalf of the person.**

41 [(1) *"Emergency medical condition" means a medical condition that manifests itself by acute*
42 *symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average*
43 *knowledge of health and medicine would reasonably expect that failure to receive immediate medical*
44 *attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious*
45 *jeopardy.*]

1 [(2) “Emergency medical screening exam” means the medical history, examination, ancillary tests
2 and medical determinations required to ascertain the nature and extent of an emergency medical con-
3 dition.]

4 [(3) “Emergency services” means those health care items and services furnished in an emergency
5 department and all ancillary services routinely available to an emergency department to the extent they
6 are required for the stabilization of a patient.]

7 [(4) (3) “Enrollee” has the meaning given that term in ORS 743.730.

8 [(5) (4) “Grievance” means [a written complaint]:

9 (a) **A request** submitted by [or on behalf of] an enrollee **or an authorized representative of**
10 **an enrollee:**

11 (A) **In writing, for an internal appeal or an external review; or**

12 (B) **In writing or orally, for an internal appeal described in ORS 743.804 (2)(e) or an ex-**
13 **pedited external review; or**

14 (b) **A complaint submitted by an enrollee or an authorized representative of an enrollee**
15 **regarding the:**

16 [(a)] (A) Availability, delivery or quality of a health care [services, including a complaint re-
17 garding an adverse determination made pursuant to utilization review] **service;**

18 [(b)] (B) Claims payment, handling or reimbursement for health care services **and, unless the**
19 **enrollee has not submitted a request for an internal appeal, the complaint is not disputing**
20 **an adverse benefit determination; or**

21 [(c)] (C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

22 [(6) (5) “Health benefit plan” has the meaning [provided for] **given** that term in ORS 743.730.

23 [(7) (6) “Independent practice association” means a corporation wholly owned by providers, or
24 whose membership consists entirely of providers, formed for the sole purpose of contracting with
25 insurers for the provision of health care services to enrollees, or with employers for the provision
26 of health care services to employees, or with a group, as described in ORS 743.522, to provide health
27 care services to group members.

28 [(8) (7) “Insurer” [has the meaning provided for that term in ORS 731.106. For purposes of ORS
29 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823,
30 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861,
31 743.862, 743.863, 743.864, 743.911, 743.912, 743.913, 743.917, 743A.012, 750.055 and 750.333, “insurer”
32 also] includes a health care service contractor as defined in ORS 750.005.

33 (8) **“Internal appeal” means a review by an insurer of an adverse benefit determination**
34 **made by the insurer.**

35 (9) “Managed health insurance” means any health benefit plan that:

36 (a) Requires an enrollee to use a specified network or networks of providers managed, owned,
37 under contract with or employed by the insurer in order to receive benefits under the plan, except
38 for emergency or other specified limited service; or

39 (b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service
40 provision that allows an enrollee to use providers outside of the specified network or networks at
41 the option of the enrollee and receive a reduced level of benefits.

42 (10) “Medical services contract” means a contract between an insurer and an independent
43 practice association, between an insurer and a provider, between an independent practice associ-
44 ation and a provider or organization of providers, between medical or mental health clinics, and
45 between a medical or mental health clinic and a provider to provide medical or mental health ser-

1 vices. "Medical services contract" does not include a contract of employment or a contract creating
2 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other
3 similar professional organizations permitted by statute.

4 (11)(a) "Preferred provider organization insurance" means any health benefit plan that:

5 (A) Specifies a preferred network of providers managed, owned or under contract with or em-
6 ployed by an insurer;

7 (B) Does not require an enrollee to use the preferred network of providers in order to receive
8 benefits under the plan; and

9 (C) Creates financial incentives for an enrollee to use the preferred network of providers by
10 providing an increased level of benefits.

11 (b) "Preferred provider organization insurance" does not mean a health benefit plan that has
12 as its sole financial incentive a hold harmless provision under which providers in the preferred
13 network agree to accept as payment in full the maximum allowable amounts that are specified in
14 the medical services contracts.

15 (12) "Prior authorization" means a determination by an insurer prior to provision of services
16 that the insurer will provide reimbursement for the services. "Prior authorization" does not include
17 referral approval for evaluation and management services between providers.

18 (13) "Provider" means a person licensed, certified or otherwise authorized or permitted by laws
19 of this state to administer medical or mental health services in the ordinary course of business or
20 practice of a profession.

21 [(14) "Stabilization" means that, within reasonable medical probability, no material deterioration
22 of an emergency medical condition is likely to occur.]

23 [(15)] (14) "Utilization review" means a set of formal techniques used by an insurer or delegated
24 by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness,
25 efficacy or efficiency of health care services, procedures or settings.

26 **SECTION 27.** ORS 743.804 is amended to read:

27 743.804. All insurers offering a health benefit plan in this state shall:

28 [(1) Have a written policy that recognizes the rights of enrollees:]

29 [(a) To voice grievances about the organization or health care provided;]

30 [(b) To be provided with information about the organization, its services and the providers pro-
31 viding care;]

32 [(c) To participate in decision making regarding their health care; and]

33 [(d) To be treated with respect and recognition of their dignity and need for privacy.]

34 [(2) Provide a summary of policies on enrollees' rights and responsibilities to all participating
35 providers upon request and to all enrollees either directly or, in the case of group coverage, to the
36 employer or other policyholder for distribution to enrollees.]

37 [(3) Have a timely and organized system for resolving grievances and appeals. The system shall
38 include:]

39 [(a) A systematic method for recording all grievances and appeals, including the nature of the
40 grievances, and significant actions taken;]

41 [(b) Written procedures explaining the grievance and appeal process, including a procedure to as-
42 sist enrollees in filing written grievances;]

43 [(c) Written decisions in plain language justifying grievance determinations, including appropriate
44 references to relevant policies, procedures and contract terms;]

45 [(d) Standards for timeliness in responding to grievances or appeals that accommodate the clinical

1 *urgency of the situation;]*

2 *[(e) Notice in all written decisions prepared pursuant to this subsection that the enrollee may file*
3 *a complaint with the Director of the Department of Consumer and Business Services; and]*

4 *[(f) An appeal process for grievances that includes at least the following:]*

5 *[(A) Three levels of review, the second of which shall be by persons not previously involved in the*
6 *dispute and the third of which shall provide external review pursuant to an external review program*
7 *meeting the requirements of ORS 743.857, 743.859 and 743.861;]*

8 *[(B) Opportunity for enrollees and any representatives of the enrollees to appear before a review*
9 *panel at either the first or second level of review. Representatives may include health care providers*
10 *or any other persons chosen by the enrollee. The enrollee and insurer shall each provide advance no-*
11 *tification of the number of representatives who will appear before the panel and the relationship of the*
12 *representatives to the enrollee or insurer; and]*

13 *[(C) Written decisions in plain language justifying appeal determinations, including specific refer-*
14 *ences to relevant provisions of the health benefit plan and related written corporate practices.]*

15 *[(4) If the insurer has a prescription drug formulary, have:]*

16 *[(a) A written procedure by which a provider with authority to prescribe drugs and medications*
17 *may prescribe drugs and medications not included in the formulary. The procedure shall include the*
18 *circumstances when a drug or medication not included in the formulary will be considered a covered*
19 *benefit; and]*

20 *[(b) A written procedure to provide full disclosure to enrollees of any cost sharing or other re-*
21 *quirements to obtain drugs and medications not included in the formulary.]*

22 *[(5) Furnish to all enrollees either directly or, in the case of a group policy, to the employer or*
23 *other policyholder for distribution to enrollees written general information informing enrollees about*
24 *services provided, access to services, charges and scheduling applicable to each enrollee's coverage,*
25 *including:]*

26 *[(a) Benefits and services included and how to obtain them, including any restrictions that apply*
27 *to services obtained outside the insurer's network or outside the insurer's service area, and the avail-*
28 *ability of continuity of care as required by ORS 743.854;]*

29 *[(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital ser-*
30 *vices and how enrollees may obtain the care or services;]*

31 *[(c) Provisions for after-hours and emergency care and how enrollees may obtain that care, in-*
32 *cluding the insurer's policy, if any, on when enrollees should directly access emergency care and use*
33 *9-1-1 services;]*

34 *[(d) Charges to enrollees, if applicable, including any policy on cost sharing for which the enrollee*
35 *is responsible;]*

36 *[(e) Procedures for notifying enrollees of:]*

37 *[(A) A change in or termination of any benefit;]*

38 *[(B) If applicable, termination of a primary care delivery office or site; and]*

39 *[(C) If applicable, assistance available to enrollees affected by the termination of a primary care*
40 *delivery office or site in selecting a new primary care delivery office or site;]*

41 *[(f) Procedures for appealing decisions adversely affecting the enrollee's benefits or enrollment*
42 *status;]*

43 *[(g) Procedures, if any, for changing providers;]*

44 *[(h) Procedures for voicing grievances, including the option of obtaining external review under the*
45 *insurer's program established pursuant to ORS 743.857, 743.859 and 743.861;]*

1 *[(i) A description of the procedures, if any, by which enrollees and their representatives may participate in the development of the insurer's corporate policies and practices;]*

2
3 *[(j) Summary information on how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization review requirements that affect coverage or payment;]*

4
5
6 *[(k) A summary of criteria used to determine if a service or drug is considered experimental or investigational;]*

7
8 *[(L) Information about provider, clinic and hospital networks, if any, including a list of network providers and information about how the enrollee may obtain current information about the availability of individual providers, the hours the providers are available and a description of any limitations on the ability of enrollees to select primary and specialty care providers;]*

9
10
11
12 *[(m) A general disclosure of any risk-sharing arrangements the insurer has with physicians and other providers;]*

13
14 *[(n) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information;]*

15
16 *[(o) A description of any assistance provided to non-English-speaking enrollees;]*

17 *[(p) A summary of the insurer's policies, if any, on drug prescriptions, including any drug formularies, cost sharing differentials or other restrictions that affect coverage of drug prescriptions;]*

18
19 *[(q) Notice of the enrollee's right to file a complaint or seek other assistance from the Director of the Department of Consumer and Business Services; and]*

20
21 *[(r) Notice of the information that is available upon request pursuant to subsection (6) of this section and information that is available from the Department of Consumer and Business Services pursuant to ORS 743.804, 743.807, 743.814 and 743.817.]*

22
23 *[(6) Provide the following information upon the request of an enrollee or prospective enrollee:]*

24 *[(a) Rules related to the insurer's drug formulary, if any, including information on whether a particular drug is included or excluded from the formulary;]*

25
26 *[(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;]*

27
28 *[(c) A copy of the insurer's annual report on grievances and appeals as submitted to the department under subsection (9) of this section;]*

29
30 *[(d) A description of the insurer's risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the federal Health Care Financing Administration pursuant to 42 C.F.R. 417.124 (3)(b) as in effect on June 18, 1997;]*

31
32 *[(e) A description of the insurer's efforts, if any, to monitor and improve the quality of health services;]*

33
34 *[(f) Information about any insurer procedures for credentialing network providers and how to obtain the names, qualifications and titles of the providers responsible for an enrollee's care; and]*

35
36 *[(g) A description of the insurer's external review program established pursuant to ORS 743.857, 743.859 and 743.861.]*

37
38 *[(7) Except as otherwise provided in this subsection, provide to enrollees, upon request, a written summary of information that the insurer may consider in its utilization review of a particular condition or disease to the extent the insurer maintains such criteria. Nothing in this section shall require an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that is proprietary shall be subject to verbal disclosure only.]*

39
40 *[(8) Provide the following information to an enrollee when the enrollee has filed a grievance:]*

1 *[(a) Detailed information on the insurer's grievance and appeal procedures and how to use them;]*

2 *[(b) Information on how to access the complaint line of the Department of Consumer and Business*
3 *Services; and]*

4 *[(c) Information explaining how an enrollee applies for external review of the insurer's actions*
5 *under the external review program established by the insurer pursuant to ORS 743.857.]*

6 *[(9) Provide annual summaries to the Department of Consumer and Business Services of the*
7 *insurer's aggregate data regarding grievances, appeals and applications for external review in a format*
8 *prescribed by the department to ensure consistent reporting on the number, nature and disposition of*
9 *grievances, appeals and applications for external review.]*

10 *[(10) Ensure that the confidentiality of specified patient information and records is protected, and*
11 *to that end:]*

12 *[(a) Adopt and implement written confidentiality policies and procedures;]*

13 *[(b) State the insurer's expectations about the confidentiality of enrollee information and records*
14 *in medical service contracts; and]*

15 *[(c) Afford enrollees the opportunity to approve or deny the release of identifiable medical personal*
16 *information by the insurer, except as otherwise permitted or required by law.]*

17 *[(11) Notify an enrollee of the enrollee's rights under the health benefit plan at the time that the*
18 *insurer notifies the enrollee of an adverse decision. The notification shall include:]*

19 *[(a) Notice of the right of the enrollee to apply for internal and external review of the adverse de-*
20 *cision;]*

21 *[(b) A statement whether a decision by an independent review organization is binding on the*
22 *insurer and enrollee;]*

23 *[(c) A statement that if the decision is not binding on the insurer and if the insurer does not comply*
24 *with the decision, the enrollee may sue the insurer as provided in ORS 743.864; and]*

25 *[(d) Information on filing a complaint with the Director of the Department of Consumer and*
26 *Business Services.]*

27 **(1) Provide to all enrollees directly or in the case of a group policy to the employer or**
28 **other policyholder for distribution to enrollees, to all applicants, and to prospective appli-**
29 **cants upon request, the following information:**

30 **(a) The insurer's written policy on the rights of enrollees, including the right:**

31 **(A) To participate in decision making regarding the enrollee's health care.**

32 **(B) To be treated with respect and with recognition of the enrollee's dignity and need for**
33 **privacy.**

34 **(C) To have grievances handled in accordance with this section.**

35 **(D) To be provided with the information described in this section.**

36 **(b) An explanation that is culturally and linguistically appropriate of the procedures de-**
37 **scribed in subsection (2) of this section for making coverage determinations and resolving**
38 **grievances, including:**

39 **(A) The opportunity for an expedited external review of an adverse benefit determination;**

40 **(B) A statement that if an insurer does not comply with the decision of an independent**
41 **review organization under ORS 743.862, the enrollee may sue the insurer under ORS 743.864;**

42 **(C) The procedure to obtain assistance available from the insurer, if any, and from the**
43 **Department of Consumer and Business Services in filing grievances; and**

44 **(D) A description of the process for filing a complaint with the department.**

45 **(e) A summary of benefits and an explanation of coverage in a form and manner pre-**

1 scribed by the department by rule.

2 (d) A summary of the insurer's policies on prescription drugs, including:

3 (A) Cost-sharing differentials;

4 (B) Restrictions on coverage;

5 (C) Prescription drug formularies;

6 (D) Procedures by which a provider with prescribing authority may prescribe drugs not
7 included on the formulary;

8 (E) Procedures for the coverage of prescription drugs not included on the formulary; and

9 (F) A summary of the criteria for determining whether a drug is experimental or
10 investigational.

11 (e) A list of network providers and how the enrollee can obtain current information about
12 the availability of providers and how to access and schedule services with providers, includ-
13 ing clinic and hospital networks.

14 (f) Notice of the enrollee's right to select a primary care provider and specialty care
15 providers.

16 (g) How to obtain referrals for specialty care in accordance with ORS 743.856.

17 (h) Restrictions on services obtained outside of the insurer's network or service area.

18 (i) The availability of continuity of care as required by ORS 743.854.

19 (j) Procedures for accessing after-hours care and emergency services as required by ORS
20 743A.012.

21 (k) Cost-sharing requirements and other charges to enrollees.

22 (L) Procedures, if any, for changing providers.

23 (m) Procedures, if any, by which enrollees may participate in the development of the
24 insurer's corporate policies.

25 (n) A summary of how the insurer makes decisions regarding coverage and payment for
26 treatment or services, including a general description of any prior authorization and utiliza-
27 tion control requirements that affect coverage or payment.

28 (o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other
29 providers.

30 (p) A summary of the insurer's procedures for protecting the confidentiality of medical
31 records and other enrollee information.

32 (q) An explanation of assistance provided to non-English-speaking enrollees.

33 (r) Notice of the information available from the department that is filed by insurers as
34 required under ORS 743.807, 743.814 and 743.817.

35 (2) Establish procedures for making coverage determinations and resolving grievances
36 that provide for all of the following:

37 (a) Timely notice of adverse benefit determinations in a form and manner approved by
38 the department or prescribed by the department by rule.

39 (b) A method for recording all grievances, including the nature of the grievance and sig-
40 nificant action taken.

41 (c) Written decisions meeting criteria established by the Director of the Department of
42 Consumer and Business Services by rule.

43 (d) Responding to grievances in a manner that accommodates the clinical urgency of the
44 situation.

45 (e) At least one but not more than two levels of internal appeal for group health benefit

1 **plans and one level of internal appeal for individual and portability health benefit plans. If**
2 **an insurer provides:**

3 **(A) Two levels of internal appeal, a person who was involved in the consideration of the**
4 **initial denial or the first level of internal appeal may not be involved in the second level of**
5 **internal appeal; and**

6 **(B) No more than one level of internal appeal, a person who was involved in the consid-**
7 **eration of the initial denial may not be involved in the internal appeal.**

8 **(f)(A) An external review that meets the requirements of ORS 743.857, 743.859 and 743.861**
9 **and is conducted in a manner approved by the department or prescribed by the department**
10 **by rule, after the enrollee has exhausted internal appeals or after the enrollee has been**
11 **deemed to have exhausted internal appeals.**

12 **(B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to**
13 **strictly comply with this section and federal requirements for internal appeals.**

14 **(g) The opportunity for the enrollee to receive continued coverage under the health**
15 **benefit plan pending the conclusion of the internal appeal process.**

16 **(h) The opportunity for the enrollee or any authorized representative chosen by the**
17 **enrollee to:**

18 **(A) Submit for consideration by the insurer any written comments, documents, records**
19 **and other materials relating to the adverse benefit determination; and**

20 **(B) Receive from the insurer, upon request and free of charge, reasonable access to and**
21 **copies of all documents, records and other information relevant to the adverse benefit de-**
22 **termination.**

23 **(3) Establish procedures for notifying affected enrollees of:**

24 **(a) A change in or termination of any benefit; and**

25 **(b)(A) The termination of a primary care delivery office or site; and**

26 **(B) Assistance available to enrollees in selecting a new primary care delivery office or**
27 **site.**

28 **(4) Provide the information described in subsection (2) of this section and ORS 743.859**
29 **at each level of internal appeal to an enrollee who is notified of an adverse benefit determi-**
30 **nation or to an enrollee who files a grievance.**

31 **(5) Upon the request of an enrollee, applicant or prospective applicant, provide:**

32 **(a) The insurer's annual report on grievances and internal appeals submitted to the de-**
33 **partment under subsection (8) of this section.**

34 **(b) A description of the insurer's efforts, if any, to monitor and improve the quality of**
35 **health services.**

36 **(c) Information about the insurer's procedures for credentialing network providers.**

37 **(6) Provide, upon the request of an enrollee, a written summary of information that the**
38 **insurer may consider in its utilization review of a particular condition or disease, to the ex-**
39 **tent the insurer maintains such criteria. Nothing in this subsection requires an insurer to**
40 **advise an enrollee how the insurer would cover or treat that particular enrollee's disease or**
41 **condition. Utilization review criteria that are proprietary shall be subject to oral disclosure**
42 **only.**

43 **(7) Maintain for a period of at least six years written records that document all griev-**
44 **ances and internal appeals and make the written records available for examination by the**
45 **department or by an enrollee or authorized representative of an enrollee with respect to a**

1 **grievance made by the enrollee. The written records must include but are not limited to the**
2 **following:**

3 (a) **Notices and claims associated with each grievance and internal appeal.**

4 (b) **A general description of the reason for the grievance.**

5 (c) **The date the grievance was received by the insurer.**

6 (d) **The date of the internal appeal or the date of any internal appeal meeting held con-**
7 **cerning the grievance.**

8 (e) **The result of the internal appeal at each level of appeal.**

9 (f) **The name of the covered person for whom the grievance was submitted.**

10 (8) **Provide an annual summary to the department of the insurer's aggregate data re-**
11 **garding grievances, internal appeals and requests for external review in a format prescribed**
12 **by the department to ensure consistent reporting on the number, nature and disposition of**
13 **grievances, internal appeals and requests for external review.**

14 (9) **Allow the exercise of any rights described in this section by an authorized represen-**
15 **tative.**

16 **SECTION 28.** ORS 743.806 is amended to read:

17 743.806. All utilization review performed pursuant to a medical services contract to which an
18 insurer is not a party shall comply with the following:

19 (1) The criteria used in the review process and the method of development of the criteria shall
20 be made available for review to a party to such medical services contract upon request.

21 (2) A doctor of medicine or osteopathy licensed under ORS chapter 677 shall be responsible for
22 all final recommendations regarding the necessity or appropriateness of services or the site at which
23 the services are provided and shall consult as appropriate with medical and mental health specialists
24 in making such recommendations.

25 (3) Any [*patient or*] provider who has had a request for treatment or payment for services denied
26 as not medically necessary or as experimental shall be provided an opportunity for a timely appeal
27 before an appropriate medical consultant or peer review committee.

28 (4) A provider request for prior authorization of nonemergency service must be answered within
29 two business days, and qualified health care personnel must be available for same-day telephone
30 responses to inquiries concerning certification of continued length of stay.

31 **SECTION 29.** ORS 743.807 is amended to read:

32 743.807. (1) All insurers offering a health benefit plan in this state that provide utilization re-
33 view or have utilization review provided on their behalf shall file an annual summary with the De-
34 partment of Consumer and Business Services that describes all utilization review policies, including
35 delegated utilization review functions, and documents the insurer's procedures for monitoring of
36 utilization review activities.

37 (2) All utilization review activities conducted pursuant to subsection (1) of this section shall
38 comply with the following:

39 (a) The criteria used in the utilization review process and the method of development of the
40 criteria shall be made available for review to contracting providers upon request.

41 (b) A doctor of medicine or osteopathy licensed under ORS chapter 677 shall be responsible for
42 all final recommendations regarding the necessity or appropriateness of services or the site at which
43 the services are provided and shall consult as appropriate with medical and mental health specialists
44 in making such recommendations.

45 (c) Any [*patient or*] provider who has had a request for treatment or payment for services denied

1 as not medically necessary or as experimental shall be provided an opportunity for a timely appeal
2 before an appropriate medical consultant or peer review committee.

3 (d) A provider request for prior authorization of nonemergency service must be answered within
4 two business days, and qualified health care personnel must be available for same-day telephone
5 responses to inquiries concerning certification of continued length of stay.

6 **SECTION 30.** ORS 743.845 is amended to read:

7 743.845. (1) *[For purposes of this section:]*

8 [(a) “Pregnancy care” means the care necessary to support a healthy pregnancy and care related
9 to labor and delivery.]

10 [(b)] **As used in this section,** “women’s health care provider” means an obstetrician or
11 gynecologist, physician assistant specializing in women’s health, advanced registered nurse practi-
12 tioner specialist in women’s health or certified nurse midwife, practicing within the applicable lawful
13 scope of practice.

14 (2) Every health insurance policy that covers hospital, medical or surgical expenses and requires
15 an enrollee to designate a participating primary care provider shall permit a female enrollee to
16 designate a women’s health care provider as the enrollee’s primary care provider if:

17 (a) The women’s health care provider meets the standards established by the insurer in collab-
18 oration with interested parties, including but not limited to the Oregon section of the American
19 College of Obstetricians and Gynecologists; and

20 (b) The women’s health care provider requests that the insurer make the provider available for
21 designation as a primary care provider.

22 (3) If a female enrollee has designated a primary care provider who is not a women’s health care
23 provider, an insurance policy as described in subsection (2) of this section shall permit the enrollee
24 to have direct access to a women’s health care provider *[for the following services:]*, **without a re-**
25 **ferral or prior authorization, for obstetrical or gynecological care by a participating health**
26 **care professional who specializes in obstetrics or gynecology.**

27 [(a) *At least one annual preventative women’s health examination;*]

28 [(b) *Medically necessary follow-up visits resulting from a preventative women’s health examination.*
29 *A health plan may require the women’s health care provider to notify and consult with the enrollee’s*
30 *primary care provider; and]*

31 [(c) *Pregnancy care.*]

32 (4) The standards established by the insurer under subsection (2) of this section shall not pro-
33 hibit an insurer from establishing the maximum number of participating primary care providers and
34 participating women’s health care providers necessary to serve a defined population or geographic
35 service area.

36 **SECTION 31.** ORS 743.857 is amended to read:

37 743.857. (1) An insurer offering health benefit plans in this state shall have an external review
38 program that meets the requirements of this section and ORS *[743.859 and]* 743.861 **and rules**
39 **adopted by the Director of the Department of Consumer and Business Services to carry out**
40 **the provisions of this section and ORS 743.861.** Each insurer shall provide the external review
41 through an independent review organization that is under contract with the director *[of the De-*
42 *partment of Consumer and Business Services]* to provide external review. Each health benefit plan
43 must allow an enrollee, by applying to the insurer **or the director**, to obtain review by an inde-
44 pendent review organization of a dispute relating to an adverse *[decision]* **benefit determination**
45 by the insurer on one or more of the following:

1 (a) Whether a course or plan of treatment is medically necessary.

2 (b) Whether a course or plan of treatment is experimental or investigational.

3 (c) Whether a course or plan of treatment that an enrollee is undergoing is an active course of
4 treatment for purposes of continuity of care under ORS 743.854.

5 **(d) Whether a course or plan of treatment is delivered in an appropriate health care
6 setting and with the appropriate level of care.**

7 (2) An insurer shall incur all costs of its external review program. The insurer may not establish
8 or charge a fee payable by enrollees for conducting external review.

9 (3) When an enrollee applies for external review, the *[insurer shall request the director to]* **di-**
10 **rector shall** appoint an independent review organization. When an independent review organization
11 is appointed, the insurer shall forward all medical records and other relevant materials to the in-
12 dependent review organization *[and]* **no later than five business days after the appointment.**
13 **The insurer** shall produce additional information as requested by the independent review organ-
14 ization to the extent that the information is reasonably available to the insurer. *[The insurer shall*
15 *furnish all such records, materials and information in a timely manner in order to enable a timely*
16 *decision by the independent review organization. The director may establish timelines for the purpose*
17 *of this subsection.]* **An independent review organization may reverse the adverse benefit de-**
18 **termination if the insurer fails to furnish records, information and materials to the inde-**
19 **pendent review organization in a timely manner.**

20 **(4) An enrollee may submit additional information to the independent review organization**
21 **no later than five business days after the enrollee's receipt of notification of the appointment**
22 **of the independent review organization and the organization must consider the information**
23 **in its review.**

24 **(5) The insurer and the director shall expedite the external review:**

25 **(a) If the adverse benefit determination concerns an admission, the availability of care,**
26 **a continued stay or a health care service for a medical condition for which the enrollee re-**
27 **ceived emergency services, as defined in ORS 743A.012, and has not been discharged from a**
28 **health care facility; or**

29 *[(4) (b) [An insurer shall expedite an enrollee's case] If a provider with an established clinical*
30 *relationship to the enrollee certifies in writing and provides supporting documentation that the or-*
31 *inary time period for external review would seriously jeopardize the life or health of the enrollee*
32 *or the enrollee's ability to regain maximum function.*

33 **SECTION 32.** ORS 743.859 is amended to read:

34 743.859. *[(1)]* An insurer of a health benefit plan shall include in the plan the following state-
35 ments, in boldfaced type or otherwise emphasized:

36 *[(a)]* **(1)** A statement of the right of enrollees to apply for external review by an independent
37 review organization; and

38 *[(b) A statement of whether the insurer agrees to be bound by decisions of independent review or-*
39 *ganizations.]*

40 *[(2) If an insurer states in the health benefit plan as provided in subsection (1) of this section that*
41 *the insurer is not bound by the decisions of independent review organizations, the plan and the written*
42 *information provided by the plan must prominently disclose that:]*

43 *[(a) The insurer is not bound by the decisions of independent review organizations;]*

44 *[(b) The insurer may follow nonetheless a decision by an independent review organization; and]*

45 *[(c)]* **(2) A statement that** if the insurer does not follow a decision of an independent review

1 organization, the enrollee has the right to sue the insurer.

2 [(3) If an insurer states in the health benefit plan as provided in subsection (1) of this section that
3 the insurer is bound by the decisions of independent review organizations, the plan must prominently
4 disclose that fact. The plan must also state that the insurer agrees to act in accordance with the deci-
5 sion of the independent review organization notwithstanding the definition of medical necessity in the
6 plan.]

7 **SECTION 33.** ORS 743.861 is amended to read:

8 743.861. (1) An enrollee shall apply in writing for external review of an adverse [decision] **ben-**
9 **efit determination** by the insurer of a health benefit plan not later than the 180th day after receipt
10 of the insurer's final written decision following its **grievance and** internal [review through its
11 grievance and] appeal process under ORS 743.804. An enrollee is eligible for external review only if
12 the enrollee has satisfied the following requirements:

13 (a) The enrollee must have signed a waiver granting the independent review organization access
14 to the medical records of the enrollee.

15 (b) The enrollee must have exhausted the plan's internal [grievance] **appeal** procedures estab-
16 lished pursuant to ORS 743.804 **or be deemed to have exhausted the plan's internal appeal**
17 **procedures.** The insurer may waive the requirement of compliance with the internal [grievance]
18 **appeal** procedures and have a dispute referred directly to external review upon the enrollee's con-
19 sent. **An enrollee is deemed to have exhausted the internal appeal procedures if the insurer**
20 **fails to strictly comply with ORS 743.804 and federal requirements for internal appeals.**

21 (2) An enrollee who applies for external review of an adverse [decision] **benefit determination**
22 shall provide complete and accurate information to the independent review organization [in a timely
23 manner] **as provided in ORS 743.857.**

24 **SECTION 34.** ORS 743.862 is amended to read:

25 743.862. (1) An independent review organization shall perform the following duties when ap-
26 pointed under ORS 743.857 to review a dispute under a health benefit plan between an insurer and
27 an enrollee:

28 (a) Decide whether the dispute [is covered by the conditions established in ORS 743.857 for ex-
29 ternal review] **pertains to an adverse benefit determination** and notify the enrollee and insurer
30 in writing of the decision. If the decision is against the enrollee, the independent review organiza-
31 tion shall notify the enrollee of the right to file a complaint with or seek other assistance from the
32 [Director of the] Department of Consumer and Business Services and the availability of other as-
33 sistance as specified by the [director] **department.**

34 (b) Appoint a reviewer or reviewers as determined appropriate by the independent review or-
35 ganization.

36 (c) Notify the enrollee of information that the enrollee is required to provide and any additional
37 information the enrollee may provide, and when the information must be submitted **as provided in**
38 **ORS 743.857.**

39 (d) Notify the insurer of additional information the independent review organization requires and
40 when the information must be submitted **as provided in ORS 743.857.**

41 (e) Decide the dispute relating to the adverse [decision] **benefit determination** of the insurer
42 [under ORS 743.857 (1)] and issue the decision in writing.

43 (2) A decision by an independent review organization shall be based on expert medical judgment
44 after consideration of the enrollee's medical record, the recommendations of each of the enrollee's
45 providers, relevant medical, scientific and cost-effectiveness evidence and standards of medical

1 practice in the United States. An independent review organization must make its decision in ac-
 2 cordance with the coverage described in the health benefit plan, except that the independent review
 3 organization may override the insurer's standards for medically necessary or experimental or
 4 investigational treatment if the independent review organization determines that the standards of
 5 the insurer are unreasonable or are inconsistent with sound medical practice.

6 (3) When review is expedited, the independent review organization shall issue a decision not
 7 later than the third day after the date on which the enrollee applies to the insurer for an expedited
 8 review **or the Director of the Department of Consumer and Business Services orders an ex-**
 9 **pedited review.**

10 (4) When a review is not expedited, the independent review organization shall issue a decision
 11 not later than the 30th day after the enrollee applies to the insurer for a review **or the director**
 12 **orders a review.**

13 (5) An independent review organization shall file synopses of its decisions with the director ac-
 14 cording to the format and other requirements established by the director. The synopses shall exclude
 15 information that is confidential, that is otherwise exempt from disclosure under ORS 192.501 and
 16 192.502 or that may otherwise allow identification of an enrollee. The director shall make the syn-
 17 opses public.

18 **SECTION 35.** ORS 743.863 is amended to read:

19 743.863. (1) **An insurer shall comply in a timely manner with a decision of an independent**
 20 **review organization under ORS 743.862 that reverses, in whole or in part, an adverse benefit**
 21 **determination.** If an insurer [*has agreed under the provisions of a health benefit plan to be bound*
 22 *by the decision of an independent review organization and the insurer fails to comply with such a de-*
 23 *cision*] **fails to comply with the decision,** the Director of the Department of Consumer and Busi-
 24 ness Services [*shall*] **may** impose on the insurer a civil penalty of [*not less than \$100,000 and*] not
 25 more than \$1 million.

26 (2) A decision of an independent review organization is admissible in any legal proceeding in-
 27 volving the insurer or the enrollee and involving the disputed issues subject to external review.

28 (3) The sanctions under subsection (1) of this section and the remedies under subsection (2) of
 29 this section are in addition to and not in lieu of other sanctions, rights and remedies provided by
 30 law or contract.

31 **SECTION 36.** ORS 743.864 is amended to read:

32 743.864. (1) An enrollee who is the subject of a decision of an independent review organization
 33 has a private right of action against the insurer for damages arising from an adverse [*decision*]
 34 **benefit determination** by the insurer that is subject to external review if[.]

35 [*(a) The insurer states in the health benefit plan in which the enrollee is enrolled that the insurer*
 36 *is not bound by the decisions of an independent review organization; and]*

37 [*(b) the insurer fails to comply with the decision.*

38 (2) The Legislative Assembly intends that there is no private right of action under subsection
 39 (1) of this section if a court finds [*either subsection (1)(a) or (b)*] **subsection (1)** of this section to be
 40 unconstitutional or otherwise void.

41 **SECTION 37.** ORS 743.878 is amended to read:

42 743.878. [(1)] An insurer offering a health benefit plan as defined in ORS 743.730 must submit to
 43 the Director of the Department of Consumer and Business Services:

44 [(a)] (1) Upon request by the director, the methodology used to determine the insurer's allowable
 45 charges for out-of-network procedures and services or, if the insurer uses a third party to determine

1 the charges, the methodology used by the third party to determine allowable charges;

2 [(b)] (2) For approval, a written explanation of the method used by the insurer to determine the
3 allowable charge, that is in plain language and that must be provided upon request to enrollees di-
4 rectly, or, in the case of group coverage, to the employer or other policyholder for distribution to
5 enrollees; and

6 [(c)] (3) Information prescribed by the director as necessary to assess the effect of the disclosure
7 requirements in ORS 743.874 and 743.876 on the individual and group health insurance markets.

8 [(2) *The director shall consider the recommendations of the Health Insurance Reform Advisory*
9 *Committee in prescribing the information required for submission under subsection (1)(c) of this*
10 *section.*]

11 **SECTION 38.** ORS 743A.012 is amended to read:

12 743A.012. (1) **As used in this section:**

13 (a) **“Emergency medical condition” means a medical condition that manifests itself by**
14 **acute symptoms of sufficient severity, including severe pain, that a prudent layperson pos-**
15 **sessing an average knowledge of health and medicine would reasonably expect that failure**
16 **to receive immediate medical attention would place the health of a person, or a fetus in the**
17 **case of a pregnant woman, in serious jeopardy.**

18 (b) **“Emergency medical screening exam” means the medical history, examination, an-**
19 **cillary tests and medical determinations required to ascertain the nature and extent of an**
20 **emergency medical condition.**

21 (c) **“Emergency services” means, with respect to an emergency medical condition:**

22 (A) **An emergency medical screening exam that is within the capability of the emergency**
23 **department of a hospital, including ancillary services routinely available to the emergency**
24 **department to evaluate such emergency medical condition; and**

25 (B) **Such further medical examination and treatment as are required under 42 U.S.C.**
26 **1395dd to stabilize a patient, to the extent the examination and treatment are within the**
27 **capability of the staff and facilities available at a hospital.**

28 (d) **“Grandfathered health plan” has the meaning given that term in ORS 743.730.**

29 (e) **“Health benefit plan” has the meaning given that term in ORS 743.730.**

30 (f) **“Prior authorization” has the meaning given that term in ORS 743.801.**

31 (g) **“Stabilize” means to provide medical treatment as necessary to:**

32 (A) **Ensure that, within reasonable medical probability, no material deterioration of an**
33 **emergency medical condition is likely to occur during or to result from the transfer of the**
34 **patient from a facility; and**

35 (B) **With respect to a pregnant women who is in active labor, to perform the delivery,**
36 **including the delivery of the placenta.**

37 [(1)] (2) All insurers offering a health benefit plan shall provide coverage without prior author-
38 ization for[:]

39 [(a)] emergency [*medical screening exams*;] **services.**

40 (3) **A health benefit plan, other than a grandfathered health plan, must provide coverage**
41 **required by subsection (2) of this section:**

42 (a) **For the services of participating providers, without regard to any term or condition**
43 **of coverage other than:**

44 (A) **The coordination of benefits;**

45 (B) **An affiliation period or waiting period permitted under part 7 of the Employee Re-**

1 **tirement Income Security Act, part A of Title XXVII of the Public Health Service Act or**
2 **chapter 100 of the Internal Revenue Code;**

3 **(C) An exclusion other than an exclusion of emergency services; or**

4 **(D) Applicable cost-sharing; and**

5 *[(b) Stabilization of an emergency medical condition; and]*

6 *[(c) Emergency services provided by a nonparticipating provider if a prudent layperson possessing*
7 *an average knowledge of health and medicine would reasonably believe that the time required to go to*
8 *a participating provider would place the health of the person, or a fetus in the case of a pregnant*
9 *woman, in serious jeopardy.]*

10 **(b) For the services of a nonparticipating provider:**

11 **(A) Without imposing any administrative requirement or limitation on coverage that is**
12 **more restrictive than requirements or limitations that apply to participating providers;**

13 **(B) Without imposing a copayment amount or coinsurance rate that exceeds the amount**
14 **or rate for participating providers;**

15 **(C) Without imposing a deductible, unless the deductible applies generally to nonpartic-**
16 **ipating providers; and**

17 **(D) Subject only to an out-of-pocket maximum that applies to all services from nonpar-**
18 **ticipating providers.**

19 *[(2)]* **(4) All insurers [described in subsection (1) of this section] offering a health benefit plan**
20 **shall provide information to enrollees in plain language regarding:**

21 (a) What constitutes an emergency medical condition;

22 (b) The coverage provided for emergency services;

23 (c) How and where to obtain emergency services; and

24 (d) The appropriate use of 9-1-1.

25 *[(3)]* **(5) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1**
26 **and [shall] may not deny coverage for emergency services solely because 9-1-1 was used.**

27 *[(4)]* **(6) This section is exempt from ORS 743A.001.**

28 **SECTION 39.** ORS 743A.080 is amended to read:

29 **743A.080. (1) As used in this section, “pregnancy care” means the care necessary to sup-**
30 **port a healthy pregnancy and care related to labor and delivery.**

31 **(2) All health benefit plans as defined in ORS 743.730 must provide payment or reimbursement**
32 **for expenses associated with pregnancy care[, as defined by ORS 743.845,] and childbirth. Benefits**
33 **provided under this section shall be extended to all enrollees, enrolled spouses and enrolled depen-**
34 **dents.**

35 **SECTION 40.** ORS 743A.090 is amended to read:

36 **743A.090. (1) All individual and group health insurance policies providing hospital, medical or**
37 **surgical expense benefits that include coverage for a family member of the insured shall also provide**
38 **that the health insurance benefits applicable for children in the family shall be payable with respect**
39 **to:**

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

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

42 **(2) The coverage of [newly born] natural and adopted children required by subsection (1) of this**
43 **section shall consist of coverage of preventive health services and treatment of injury or sick-**
44 **ness, including the necessary care and treatment of medically diagnosed congenital defects and birth**
45 **abnormalities.**

1 (3) If payment of [*a specific*] **an additional** premium is required to provide coverage for a child,
2 the policy may require that notification of the birth of the child or of the placement for adoption
3 of the child and payment of the premium be furnished **to** the insurer within 31 days after the date
4 of birth or date of placement in order to **effectuate the coverage required by this section and**
5 **to** have the coverage extended beyond the 31-day period.

6 (4) [*The following requirements apply to coverage of an adopted child required by subsection (1)(b)*
7 *of this section:*]

8 [(a)] In any case in which a policy provides coverage for dependent children of participants or
9 beneficiaries, the policy shall provide benefits to dependent children placed with participants or
10 beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent
11 children of the participants and beneficiaries, regardless of whether the adoption has become final.

12 [(b) *A policy may not restrict coverage of any dependent child adopted by a participant or benefi-*
13 *ciary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting*
14 *condition of the child at the time that the child would otherwise become eligible for coverage under the*
15 *plan if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for*
16 *coverage under the plan.*]

17 (5) As used in this section:

18 (a) “Child” means, in connection with any adoption, or placement for adoption of the child, an
19 individual who [*has not attained 18 years of age*] **is under 18 years of age** as of the date of the
20 adoption or placement for adoption **and who is under 26 years of age as of the date of the pro-**
21 **vision of a benefit under the policy.**

22 (b) “Placement for adoption” means the assumption and retention by a person of a legal obli-
23 gation for total or partial support of a child in anticipation of the adoption of the child. The child’s
24 placement with a person terminates upon the termination of such legal obligations.

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

26 **SECTION 41.** ORS 743A.110 is amended to read:

27 743A.110. (1) All insurers offering a health benefit plan as defined in ORS 743.730 shall provide
28 payment, coverage or reimbursement for the following mastectomy-related services as determined
29 by the attending physician and enrollee to be part of the enrollee’s course or plan of treatment:

30 (a) All stages of reconstruction of the breast on which a mastectomy was performed, including
31 but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;

32 (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

33 (c) Prostheses;

34 (d) Treatment of physical complications of the mastectomy, including lymphedemas; and

35 (e) Inpatient care related to the mastectomy and post-mastectomy services.

36 (2) An insurer providing coverage under subsection (1) of this section shall provide written no-
37 tice describing the coverage to the enrollee at the time of enrollment in the health benefit plan and
38 annually thereafter.

39 (3) A health benefit plan must provide a single determination of prior authorization for all
40 mastectomy-related services covered under subsection (1) of this section that are part of the
41 enrollee’s course or plan of treatment.

42 (4) When an enrollee requests an external review of an adverse [*decision*] **benefit determi-**
43 **nation as defined in ORS 743.801** by the insurer regarding services described in subsection (1) of
44 this section, the insurer **or the Director of the Department of Consumer and Business Services**
45 must expedite the enrollee’s case pursuant to ORS 743.857 [(4)] (5).

1 (5) The coverage required under subsection (1) of this section is subject to the same terms and
2 conditions in the plan that apply to other benefits under the plan.

3 (6) This section is exempt from ORS 743A.001.

4 **SECTION 42.** ORS 746.650 is amended to read:

5 746.650. **Except as otherwise provided in ORS 743.804, 743.806, 743.857 and 743.861:**

6 (1) In the event of an adverse underwriting decision, the insurer or insurance producer respon-
7 sible for the decision must:

8 (a) Either provide the consumer proposed for coverage with the specific reason or reasons for
9 the adverse underwriting decision in writing or advise the consumer that upon written request the
10 consumer may receive the specific reason or reasons in writing; and

11 (b) Provide the consumer proposed for coverage with a summary of the rights established under
12 subsection (2) of this section and ORS 746.640 and 746.645.

13 (2) Upon receipt of a written request within 90 business days from the date of the mailing of
14 notice or other communication of an adverse underwriting decision to a consumer proposed for
15 coverage, the insurer or insurance producer shall furnish to the consumer within 21 business days
16 from the date of receipt of the written request:

17 (a) The specific reason or reasons for the adverse underwriting decision, in writing, if this in-
18 formation was not initially furnished in writing pursuant to subsection (1) of this section;

19 (b) The specific items of personal information and privileged information that support these
20 reasons, subject to the following:

21 (A) The insurer or insurance producer is not required to furnish specific items of privileged in-
22 formation if the insurer or insurance producer has a reasonable suspicion, based upon specific in-
23 formation available for review by the Director of the Department of Consumer and Business
24 Services, that the consumer proposed for coverage has engaged in criminal activity, fraud, material
25 misrepresentation or material nondisclosure; and

26 (B) Specific items of individually identifiable health information supplied by a health care pro-
27 vider shall be disclosed either directly to the consumer about whom the information relates or to
28 a health care provider designated by the consumer and licensed to provide health care with respect
29 to the condition to which the information relates, whichever the insurer or insurance producer
30 prefers; and

31 (c) The names and addresses of the institutional sources that supplied the specific items of in-
32 formation described in paragraph (b) of this subsection. However, the identity of any health care
33 provider must be disclosed either directly to the consumer or to the designated health care provider,
34 whichever the insurer or insurance producer prefers.

35 (3) The obligations imposed by this section upon an insurer or insurance producer may be sat-
36 isfied by another insurer or insurance producer authorized to act on its behalf.

37 (4) When an adverse underwriting decision results solely from an oral request or inquiry, the
38 explanation of reasons and summary of rights required by subsection (1) of this section may be given
39 orally.

40 (5) Notwithstanding subsection (1) of this section, when an adverse underwriting decision is
41 based in whole or in part on credit history or insurance score, the insurer or insurance producer
42 responsible for the decision must provide the consumer proposed for coverage with the specific
43 reason or reasons for the adverse underwriting decision in writing. The notice must include the
44 following:

45 (a) A summary of no more than four of the most significant credit reasons for the adverse

1 underwriting decision, listed in decreasing order of importance, that clearly identifies the specific
2 credit history or insurance score used to make the adverse underwriting decision. An insurer or
3 insurance producer may not use “poor credit history” or a similar phrase as a reason for an adverse
4 underwriting decision.

5 (b) The name, address and telephone number, including a toll-free telephone number, of the
6 consumer reporting agency that provided the information for the consumer report.

7 (c) A statement that the consumer reporting agency used by the insurer or insurance producer
8 to obtain the credit history of the consumer did not make the adverse underwriting decision and is
9 unable to provide the consumer with specific reasons why the insurer or insurance producer made
10 an adverse underwriting decision.

11 (d) Information on the right of the consumer:

12 (A) To obtain a free copy of the consumer’s consumer report from the consumer reporting
13 agency described in paragraph (b) of this subsection, including the deadline, if any, for obtaining a
14 copy; and

15 (B) To dispute the accuracy or completeness of any information in a consumer report furnished
16 by the consumer reporting agency.

17 (6) Notwithstanding subsection (1) of this section, an insurer or insurance producer responsible
18 for an adverse underwriting decision that is based in whole or in part on credit history or insurance
19 score must provide the notice required by subsection (5) of this section only when the insurer or
20 insurance producer makes the initial adverse underwriting decision regarding a consumer.

21 (7) Notwithstanding subsection (1) of this section, when an adverse underwriting decision relat-
22 ing to homeowner insurance is based in whole or in part on a loss history report, the insurer or
23 insurance producer responsible for the decision must provide the consumer proposed for coverage
24 with the specific reason or reasons for the adverse underwriting decision in writing. The notice must
25 include the following:

26 (a) A description of a specific claim or claims that are the basis for the specific loss history
27 report used to make the adverse underwriting decision.

28 (b) The name, address and telephone number, including a toll-free telephone number, of the
29 consumer reporting agency that provided the information for the loss history report.

30 (c) A statement that the consumer reporting agency used by the insurer or insurance producer
31 to obtain the loss history report of the consumer did not make the adverse underwriting decision
32 and is unable to provide the consumer with specific reasons why the insurer or insurance producer
33 made an adverse underwriting decision.

34 (d) Information on the right of the consumer:

35 (A) To obtain a free copy of the consumer’s loss history report from the consumer reporting
36 agency described in paragraph (b) of this subsection, including the deadline, if any, for obtaining a
37 copy; and

38 (B) To dispute the accuracy or completeness of any information in a loss history report fur-
39 nished by the consumer reporting agency.

40 (8) When an adverse underwriting decision relating to homeowner insurance is based in part on
41 credit history and in part on a loss history report, the insurer or insurance producer responsible for
42 the adverse underwriting decision may provide the notices required by subsections (5) and (7) of this
43 section in a single notice.

44 **SECTION 43.** ORS 750.055 is amended to read:

45 750.055. (1) The following provisions of the Insurance Code apply to health care service con-

1 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

2 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,
3 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,
4 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,
5 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992 and 731.870.

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

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

10 (d) ORS chapter 734.

11 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to
12 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,
13 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552,
14 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842,
15 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911,
16 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.036, 743A.048, 743A.058, 743A.062,
17 743A.064, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
18 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.160, 743A.164, 743A.168, 743A.170,
19 743A.175, 743A.184, 743A.188, 743A.190 and 743A.192 **and sections 2 and 4 of this 2011 Act.**

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

21 (g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
22 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

26 (i) ORS 735.600 to 735.650.

27 (j) ORS 743.680 to 743.689.

28 (k) ORS 744.700 to 744.740.

29 (L) ORS 743.730 to 743.773.

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

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

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

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

40 **SECTION 44.** ORS 750.333 is amended to read:

41 750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a mul-
42 tiple employer welfare arrangement:

43 (a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
44 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
45 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652 and 731.804 to 731.992.

1 (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.

2 (c) ORS chapter 734.

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

4 (e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562,
5 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 743.804,
6 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858,
7 743.859, 743.861, 743.862, 743.863, 743.864, 743.912, 743.917, 743A.012, 743A.020, 743A.052, 743A.064,
8 743A.080, 743A.100, 743A.104, 743A.110, 743A.144, 743A.170, 743A.175, 743A.184 and 743A.192 **and**
9 **sections 2 and 4 of this 2011 Act.**

10 (f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048,
11 743A.058, 743A.066, 743A.068, 743A.070, 743A.084, 743A.088, 743A.090, 743A.105, 743A.140, 743A.141,
12 743A.148, 743A.168, 743A.180, 743A.188 and 743A.190. Multiple employer welfare arrangements to
13 which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only
14 as provided in ORS 743.730 to 743.773.

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

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

18 (i) ORS 731.592 and 731.594.

19 (j) ORS 731.870.

20 (2) For the purposes of this section:

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

22 (b) References to certificates of authority shall be considered references to certificates of mul-
23 tiple employer welfare arrangement.

24 (c) Contributions shall be considered premiums.

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

27 **SECTION 45.** Section 4, chapter 75, Oregon Laws 2010, is amended to read:

28 **Sec. 4.** (1) An insurer who elects to offer discounted rates for a health insurance plan utilizing
29 electronic administration shall include the schedule of discounts for utilization of electronic admin-
30 istration as part of a small employer group health insurance or individual health insurance rate
31 filing. The rate discounts may be graduated and must be proportionate to the amount of adminis-
32 trative cost savings the insurer anticipates as a result of the use of electronic transactions described
33 in section **3, chapter 75, Oregon Laws 2010** [3 of this 2010 Act].

34 (2) Discounted rates allowed under this section shall be applied uniformly to all similarly situ-
35 ated small employer group or individual health insurance purchasers of an insurer.

36 (3) Discounts in premium rates under this section are not premium rate variations for purposes
37 of ORS 743.737 [(8)] (10) or 743.767.

38 **SECTION 46.** The Health Insurance Reform Advisory Committee is abolished.

39 **SECTION 47.** Sections 2 and 4 of this 2011 Act, the amendments to statutes and session
40 laws by sections 5 to 9, 12, 14 to 17 and 19 to 45 of this 2011 Act apply to policies or certif-
41 icates issued or renewed on or after September 23, 2010, and in effect on or after the effec-
42 tive date of this 2011 Act.

43 **SECTION 48.** This 2011 Act being necessary for the immediate preservation of the public
44 peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect
45 on its passage.

