Senate Bill 90

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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 **as introduced.**

Prohibits insurer from canceling, rescinding or refusing to renew policy except for fraud or intentional misrepresentation of material fact. Applies to policies issued or renewed on or after September 23, 2010.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; amending ORS 743.737, 743.754, 743.760, 743.766, 743.801, 750.055 and 750.333 and section 4, chapter 75, Oregon Laws 2010; and declaring an emergency.

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

SECTION 1. Section 2 of this 2011 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) An insurer may not rescind a health benefit plan or the coverage of any individual under a group or individual health insurance policy unless:

(a)(A) The individual or a person seeking coverage on behalf of the individual performs an act, practice or omission that constitutes fraud; or

(B) The individual makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan or policy; and

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

(2) An insurer that rescinds a plan or policy must provide notice of the rescission to the department in the form and manner prescribed by the department no later than 30 days after the date that the rescission takes effect.

(3) As used in this section, "a person seeking coverage on behalf of the individual" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

SECTION 3. ORS 743.737 is amended to read:

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

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

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.

enrollment date of a late enrollee shall be the effective date of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) of this] subsection **(5)(e) and (g) of this section**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Provisions affecting any preexisting conditions provision.

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

(b) [*Each small employer*] **A** carrier **offering a small employer health benefit plan** shall file with the [*director*] **department** at least once every 12 months an actuarial certification that the

carrier is in compliance with ORS 743.733 to 743.737 and that the rating methods of the [*small employer*] carrier are actuarially sound. Each [*such*] certification shall be in a uniform form and manner and shall contain such information as specified by the [*director*] **department**. A copy of [*such*] **each** certification shall be retained by the [*small employer*] carrier at its principal place of business.

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

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

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

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

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

SECTION 4. ORS 743.754 is amended to read:

743.754. The following requirements apply to all group health benefit plans covering two or more certificate holders:

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

(2) A preexisting conditions provision in a group health benefit plan shall [*terminate its effect*] **expire** as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) May not cancel coverage under the plan for 90 days after the date of the notice required

under subparagraph (A) of this paragraph; and

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

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

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

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

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

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

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

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

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

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

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

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

[*(7)*] **(8)** Notwithstanding any provision of subsection (6) of this section to the contrary, a **carrier may rescind a** group health benefit plan**, or coverage of an enrollee under a group health benefit plan,** [*may be rescinded by a carrier for fraud, material misrepresentation or concealment by a policyholder and the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.*] **if the enrollee:**

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

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

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

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

SECTION 5. ORS 743.760 is amended to read:

743.760. (1) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

(5) Within 180 days after approval by the director of the portability plans submitted by the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) [*When*] The carrier elects to discontinue offering all of its group health benefit plans in ac-

cordance with ORS 743.737 and 743.754; or

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

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

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

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

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

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

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

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

(13) A carrier may rescind a portability health benefit plan issued to a policyholder if the policyholder:

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

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

SECTION 6. ORS 743.766 is amended to read:

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

(2)(a) If an individual is accepted for coverage under an individual health benefit plan, the car-

rier shall not impose exclusions or limitations [*on coverage greater*] **other** than:

(A) A preexisting conditions provision that complies with the following requirements:

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

(ii) The provision shall terminate its effect no later than six months following the individual's effective date of coverage;

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

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

(b) Pregnancy may constitute a preexisting condition for purposes of this section.

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

(4) If an eligible prospective enrollee is rejected for coverage under an individual health benefit plan, the prospective enrollee shall be eligible to apply for coverage under the Oregon Medical Insurance Pool.

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

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

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

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

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

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

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

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

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

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

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

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

(e) [*When*] The carrier discontinues offering or renewing, or offering and renewing, an individual health benefit plan for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection. With respect to plans that are being discontinued, the carrier must:

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

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

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

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

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

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

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

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

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

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

[*(6)*] **(7)** Notwithstanding any other provision of this section, a carrier may rescind an individual health benefit plan [*for fraud, material misrepresentation or concealment by an enrollee.*] **if the policyholder:**

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

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

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

[*(8)*] **(9)** A carrier that continues to offer coverage in the individual market in this state is not

required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier elects to continue a plan that is closed to new individual policyholders instead of offering alternative coverage in its other individual health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (5) of this section.

SECTION 7. ORS 743.801 is amended to read:

743.801. As used in **this section and** ORS [*743.801,*] 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.912, 743.913, 743.917, 743.918**,** [*and*] 743A.012 **and 750.333 and section 2 of this 2011 Act**:

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

(2) "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

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

(4) "Enrollee" has the meaning given that term in ORS 743.730.

(5) "Grievance" means a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and an insurer.

(6) "Health benefit plan" has the meaning provided for that term in ORS 743.730.

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

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

(9) "Managed health insurance" means any health benefit plan that:

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

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

(10) "Medical services contract" means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. "Medical services contract" does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

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

(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

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

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

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

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

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

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

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

SECTION 8. Section 4, chapter 75, Oregon Laws 2010, is amended to read:

Sec. 4. (1) An insurer who elects to offer discounted rates for a health insurance plan utilizing electronic administration shall include the schedule of discounts for utilization of electronic administration as part of a small employer group health insurance or individual health insurance rate filing. The rate discounts may be graduated and must be proportionate to the amount of administrative cost savings the insurer anticipates as a result of the use of electronic transactions described in section 3 [*of this 2010 Act*]**, chapter 75, Oregon Laws 2010**.

(2) Discounted rates allowed under this section shall be applied uniformly to all similarly situated small employer group or individual health insurance purchasers of an insurer.

(3) Discounts in premium rates under this section are not premium rate variations for purposes of ORS 743.737 [*(8)*] **(9)** or 743.767.

SECTION 9. ORS 750.055 is amended to read:

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

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,

731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992 and 731.870.

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

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

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.188, 743A.190 and 743A.192 **and section 2 of this 2011 Act**.

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

(g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

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

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

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

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

SECTION 10. ORS 750.333 is amended to read:

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

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

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

(c) ORS chapter 734.

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

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.912, 743.917, 743A.012, 743A.020, 743A.052, 743A.064, 743A.080, 743A.100, 743A.104, 743A.110, 743A.144, 743A.170, 743A.175, 743A.184 and 743A.192 **and section 2 of this 2011 Act**.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048, 743A.058, 743A.066, 743A.068, 743A.070, 743A.084, 743A.088, 743A.090, 743A.105, 743A.140, 743A.141, 743A.148, 743A.168, 743A.180, 743A.188 and 743A.190. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

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

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

(i) ORS 731.592 and 731.594.

(j) ORS 731.870.

(2) For the purposes of this section:

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

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

(c) Contributions shall be considered premiums.

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

SECTION 11. Section 2 of this 2011 Act and the amendments to ORS 743.737, 743.754, 743.760, 743.766, 743.801, 750.055 and 750.333 and section 4, chapter 75, Oregon Laws 2010, by sections 3 to 10 of this 2011 Act apply to policies issued or renewed on or after September 23, 2010.

SECTION 12. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.