

# D R A F T

## SUMMARY

Establishes Oregon Supplemental Reinsurance Program to be administered by Oregon Medical Insurance Pool Board. Terminates Oregon Medical Insurance Pool and Temporary High Risk Pool Program. Ends Oregon Supplemental Reinsurance Program on December 31, 2016, and abolishes board on July 1, 2017.

Declares emergency, effective on passage.

## A BILL FOR AN ACT

1  
2 Relating to insurance; creating new provisions; amending ORS 65.957,  
3 192.556, 291.055, 414.841, 705.145, 731.036, 731.509, 734.790, 735.610, 735.612,  
4 735.616, 735.625, 735.630, 735.635, 735.645, 735.650, 743.402, 743.730, 743.748,  
5 743.766, 743.767, 743.769, 744.704, 746.600, 748.603 and 750.055 and section  
6 5, chapter 47, Oregon Laws 2010; repealing ORS 414.866, 414.868, 414.870,  
7 414.872, 735.600, 735.605, 735.610, 735.612, 735.614, 735.615, 735.616, 735.620,  
8 735.625, 735.630, 735.635, 735.640, 735.645, 735.650 and 746.222 and section  
9 1, chapter 803, Oregon Laws 2009; and declaring an emergency.

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

## 11 12 ESTABLISHMENT OF THE 13 OREGON SUPPLEMENTAL REINSURANCE PROGRAM 14

15 **SECTION 1. The Oregon Supplemental Reinsurance Program is es-**  
16 **tablished in the Oregon Health Authority. The program shall be ad-**  
17 **ministered by the Oregon Medical Insurance Pool Board, created in**  
18 **ORS 735.610, for the purposes of stabilizing the rates and premiums for**

1 individual health benefit plans and providing greater financial cer-  
2 tainty to consumers of health insurance in this state by providing  
3 state supplemental reinsurance payments to insurers from assess-  
4 ments described in section 2 of this 2013 Act.

5 **SECTION 2.** (1) As used in this section, section 1 of this 2013 Act  
6 and ORS 735.610:

7 (a) "Health benefit plan" has the meaning given in ORS 743.730.

8 (b) "Insurer" has the meaning given that term in ORS 735.605.

9 (c) "Program" means the Oregon Supplemental Reinsurance Pro-  
10 gram established in section 1 of this 2013 Act.

11 (d) "Reinsurance eligible health benefit plan" means a health ben-  
12 efit plan providing individual coverage that is not a grandfathered  
13 health plan as defined in ORS 743.730 and that meets the criteria pre-  
14 scribed by the Oregon Medical Insurance Pool Board under subsection  
15 (2) of this section.

16 (e) "Reinsurance eligible individual" means an individual insured  
17 under a reinsurance eligible health benefit plan:

18 (A) Who, on December 31, 2013, was:

19 (i) Enrolled in the Oregon Medical Insurance Pool, created by ORS  
20 735.610, the Temporary High Risk Pool Program, established by section  
21 1, chapter 47, Oregon Laws 2010, or a federally administered medical  
22 insurance pool for high risk individuals; or

23 (ii) Insured under a portability health benefit plan as defined in  
24 ORS 743.760; or

25 (B) Whose coverage was reinsured under the reinsurance program  
26 for children's coverage described in ORS 735.614 (1)(b).

27 (2) The board shall prescribe by rule the criteria for a health benefit  
28 plan to qualify for reinsurance payments under the program. The cri-  
29 teria must be consistent with requirements for:

30 (a) Premium rates under 42 U.S.C. 300gg;

31 (b) Guaranteed availability under 42 U.S.C. 300gg-1;

1 (c) **Guaranteed renewability under 42 U.S.C. 300gg-2;**

2 (d) **Coverage of essential health benefits under 42 U.S.C. 18022; and**

3 (e) **Using a single risk pool under 42 U.S.C. 18032(c).**

4 (3) **An issuer of a reinsurance eligible health benefit plan becomes**  
5 **eligible for a reinsurance payment when the claims costs for a rein-**  
6 **surance eligible individual's covered benefits in a calendar year exceed**  
7 **the attachment point. The amount of the payment shall be the product**  
8 **of the coinsurance rate and the issuer's claims costs for the reinsur-**  
9 **ance eligible individual's claims costs that exceed the attachment**  
10 **point, up to the reinsurance cap, as follows:**

11 (a) **For 2014:**

12 (A) **The attachment point is \$30,000.**

13 (B) **The coinsurance rate is:**

14 (i) **10 percent of the amount of the claims costs above \$60,000 and**  
15 **up to and including \$250,000; and**

16 (ii) **90 percent of the amount of the claims costs from \$30,000 and**  
17 **up to and including \$60,000 and above \$250,000.**

18 (C) **The reinsurance cap is \$300,000.**

19 (b) **The board shall adopt by rule an attachment point, coinsurance**  
20 **rate and reinsurance cap for calendar years 2015 and 2016, consistent**  
21 **with federal requirements, so that assessments collected under sub-**  
22 **section (4) of this section will be sufficient to pay all reinsurance**  
23 **payments that are due. After the rules required under this paragraph**  
24 **are adopted for a calendar year, the board may not:**

25 (A) **Decrease the attachment point adopted for that calendar year;**

26 (B) **Increase the coinsurance rate adopted for that calendar year;**

27 **or**

28 (C) **Increase the reinsurance cap adopted for that calendar year.**

29 (4) **The board shall impose an assessment on all insurers at a rate**  
30 **that is expected to produce an amount of funds equal to reinsurance**  
31 **payments that are due to issuers of reinsurance eligible health benefit**

1 **plans in a calendar year, but not greater than the rate that would be**  
2 **expected to produce funds totalling the lesser of:**

3 **(a) An amount per month multiplied by the number of insureds and**  
4 **certificate holders in this state who are insured or reinsured, other**  
5 **than through the program or a federal reinsurance program; or**

6 **(b) The total assessment set forth in subsection (5) of this section.**

7 **(5) The amount per month and total assessment are as follows:**

8 **(a) For calendar year 2014, the amount per month is \$4 and the total**  
9 **assessment is \$72 million.**

10 **(b) For calendar year 2015, the amount per month is \$3.50 and the**  
11 **total assessment is \$63 million.**

12 **(c) For calendar year 2016, the amount per month is \$2.20 and the**  
13 **total assessment is \$40 million.**

14 **(6) If the board collects assessments that exceed the amount nec-**  
15 **essary to make all of the reinsurance payments that are due to issuers**  
16 **of reinsurance eligible health benefit plans in a calendar year, the**  
17 **board shall reduce the amount of the prospective assessments or re-**  
18 **fund the excess to issuers of reinsurance eligible health benefit plans**  
19 **on a pro rata basis.**

20 **(7) The board may not impose an assessment under subsection (4)**  
21 **of this section for calendar years beginning with 2017.**

22 **(8) The board, in consultation with the Department of Consumer**  
23 **and Business Services, may adopt rules necessary to carry out the**  
24 **provisions of this section in a manner consistent with federal re-**  
25 **quirements under 42 U.S.C. 18061, including, but not limited to rules**  
26 **prescribing:**

27 **(a) The eligibility requirements for participation in the program by**  
28 **an issuer of a reinsurance eligible health benefit plan;**

29 **(b) The form and manner of issuing notices of assessment amounts;**

30 **(c) The amount, manner and frequency of the payment and col-**  
31 **lection of assessments;**

1 (d) The amount, manner and frequency of reinsurance payments;  
2 and

3 (e) Reporting requirements for insurers subject to the assessment  
4 and for issuers of reinsurance eligible health benefit plans.

5 (9) The board shall comply will all reporting, notification, record-  
6 keeping and record retention requirements under 42 U.S.C. 18061.

7 **SECTION 3.** Section 4 of this 2013 Act is added to and made a part  
8 of the Insurance Code.

9 **SECTION 4.** (1) As used in this section:

10 (a) "Health benefit plan" has the meaning given that term in ORS  
11 743.730.

12 (b) "Oregon Medical Insurance Pool Board" means the board cre-  
13 ated in ORS 735.610.

14 (c) "Oregon Supplemental Reinsurance Program" means the pro-  
15 gram created in section 1 of this 2013 Act.

16 (d) "Reinsurance eligible individual" has the meaning given that  
17 term in section 2 of this 2013 Act.

18 (2) An insurer that offers a health benefit plan must report to the  
19 Oregon Medical Insurance Pool Board, in the form and manner pre-  
20 scribed by the board by rule, information about reinsurance eligible  
21 individuals insured by the health benefit plan, as necessary for the  
22 board to calculate reinsurance payments under the Oregon Supple-  
23 mental Reinsurance Program.

24 **SECTION 5.** ORS 731.509 is amended to read:

25 731.509. (1) The purpose of ORS 731.509, 731.510, 731.511, 731.512 and  
26 731.516 is to protect the interests of insureds, claimants, ceding insurers,  
27 assuming insurers and the public generally. The Legislative Assembly de-  
28 clares that its intent is to ensure adequate regulation of insurers and re-  
29 insurers and adequate protection for those to whom they owe obligations. In  
30 furtherance of that state interest, the Legislative Assembly mandates that  
31 upon the insolvency of an alien insurer or reinsurer that provides security

1 to fund its United States obligations in accordance with ORS 731.509, 731.510,  
2 731.511, 731.512 and 731.516, the assets representing the security shall be  
3 maintained in the United States and claims shall be filed with and valued  
4 by the state insurance commissioner with regulatory oversight, and the as-  
5 sets shall be distributed in accordance with the insurance laws of the state  
6 in which the trust is domiciled that are applicable to the liquidation of do-  
7 mestic United States insurers. The Legislative Assembly declares that the  
8 laws contained in ORS 731.509, 731.510, 731.511, 731.512 and 731.516 are fun-  
9 damental to the business of insurance in accordance with 15 U.S.C. 1011 and  
10 1012.

11 (2) The Director of the Department of Consumer and Business Services  
12 shall not allow credit for reinsurance to a domestic ceding insurer as either  
13 an asset or a reduction from liability on account of reinsurance ceded unless  
14 credit is allowed as provided under ORS 731.508 and unless the reinsurer  
15 meets the requirements of:

- 16 (a) Subsection (3) of this section;
- 17 (b) Subsection (4) of this section;
- 18 (c) Subsections (5) and (8) of this section;
- 19 (d) Subsections (6) and (8) of this section; [*or*]
- 20 (e) Subsection (7) of this section[.]; **or**
- 21 **(f) Subsection (9) of this section.**

22 (3) Credit shall be allowed when the reinsurance is ceded to an authorized  
23 assuming insurer that accepts reinsurance of risks, and retains risk thereon  
24 within such limits, as the assuming insurer is otherwise authorized to insure  
25 in this state as provided in ORS 731.508.

26 (4) Credit shall be allowed when the reinsurance is ceded to an assuming  
27 insurer that is accredited as a reinsurer in this state as provided in ORS  
28 731.511. The director shall not allow credit to a domestic ceding insurer if  
29 the accreditation of the assuming insurer has been revoked by the director  
30 after notice and opportunity for hearing.

31 (5) Credit shall be allowed when the reinsurance is ceded to a foreign

1 assuming insurer or a United States branch of an alien assuming insurer  
2 meeting all of the following requirements:

3 (a) The foreign assuming insurer must be domiciled in a state employing  
4 standards regarding credit for reinsurance that equal or exceed the standards  
5 applicable under this section. The United States branch of an alien assuming  
6 insurer must be entered through a state employing such standards.

7 (b) The foreign assuming insurer or United States branch of an alien as-  
8 suming insurer must maintain a combined capital and surplus in an amount  
9 not less than \$20,000,000. The requirement of this paragraph does not apply  
10 to reinsurance ceded and assumed pursuant to pooling arrangements among  
11 insurers in the same holding company system.

12 (c) The foreign assuming insurer or United States branch of an alien as-  
13 suming insurer must submit to the authority of the director to examine its  
14 books and records.

15 (6) Credit shall be allowed when the reinsurance is ceded to an assuming  
16 insurer that maintains a trust fund meeting the requirements of this sub-  
17 section and additionally complies with other requirements of this subsection.  
18 The trust fund must be maintained in a qualified United States financial  
19 institution, as defined in ORS 731.510 (1), for the payment of the valid claims  
20 of its United States policyholders and ceding insurers and their assigns and  
21 successors in interest. The assuming insurer must report annually to the di-  
22 rector information substantially the same as that required to be reported on  
23 the annual statement form by ORS 731.574 by authorized insurers, in order  
24 to enable the director to determine the sufficiency of the trust fund. The  
25 following requirements apply to such a trust fund:

26 (a) In the case of a single assuming insurer, the trust fund must consist  
27 of funds in trust in an amount not less than the assuming insurer's liabilities  
28 attributable to reinsurance ceded by United States ceding insurers. In addi-  
29 tion, the assuming insurer must maintain a trusted surplus of not less than  
30 \$20,000,000.

31 (b) In the case of a group including incorporated and individual unincor-

1 porated underwriters:

2 (A) For reinsurance ceded under reinsurance agreements with an incep-  
3 tion, amendment or renewal date on or after August 1, 1995, the trust shall  
4 consist of a trustee account in an amount not less than the group's several  
5 liabilities attributable to business ceded by United States domiciled ceding  
6 insurers to any member of the group.

7 (B) For reinsurance ceded under reinsurance agreements with an incep-  
8 tion date on or before July 31, 1995, and not amended or renewed after that  
9 date, notwithstanding the other provisions of ORS 731.509, 731.510, 731.511,  
10 731.512 and 731.516, the trust shall consist of a trustee account in an  
11 amount not less than the group's several insurance and reinsurance liabil-  
12 ities attributable to business written in the United States.

13 (C) In addition to the trusts described in subparagraphs (A) and (B) of  
14 this paragraph, the group shall maintain in trust a trustee surplus of which  
15 \$100,000,000 shall be held jointly for the benefit of the United States  
16 domiciled ceding insurers of any member of the group for all years of ac-  
17 count.

18 (D) The incorporated members of the group shall not be engaged in any  
19 business other than underwriting as a member of the group and shall be  
20 subject to the same level of regulation and solvency control by the group's  
21 domiciliary regulator as are the unincorporated members.

22 (E) Within 90 days after the group's financial statements are due to be  
23 filed with the group's domiciliary regulator, the group shall provide to the  
24 director an annual certification by the group's domiciliary regulator of the  
25 solvency of each underwriter member or, if certification is unavailable, fi-  
26 nancial statements of each underwriter member of the group prepared by  
27 independent certified public accountants.

28 (c) In the case of a group of incorporated insurers described in this par-  
29 agraph, the trust must be in an amount equal to the group's several liabil-  
30 ities attributable to business ceded by United States ceding insurers to any  
31 member of the group pursuant to reinsurance contracts issued in the name



1 of the group. This paragraph applies to a group of incorporated insurers  
2 under common administration that complies with the annual reporting re-  
3 quirements contained in this subsection and that has continuously transacted  
4 an insurance business outside the United States for at least three years im-  
5 mediately prior to making application for accreditation. Such a group must  
6 have an aggregate policyholders' surplus of \$10,000,000,000 and must submit  
7 to the authority of this state to examine its books and records and bear the  
8 expense of the examination. The group shall also maintain a joint trusteed  
9 surplus of which \$100,000,000 must be held jointly for the benefit of United  
10 States ceding insurers of any member of the group as additional security for  
11 any such liabilities. Each member of the group shall make available to the  
12 director an annual certification of the member's solvency by the member's  
13 domiciliary regulator and its independent certified public accountant.

14 (d) The form of the trust and any amendment to the trust shall have been  
15 approved by the insurance commissioner of the state in which the trust is  
16 domiciled or by the insurance commissioner of another state who, pursuant  
17 to the terms of the trust instrument, has accepted principal regulatory  
18 oversight of the trust.

19 (e) The form of the trust and any trust amendments also shall be filed  
20 with the insurance commissioner of every state in which the ceding insurer  
21 beneficiaries of the trust are domiciled. The trust instrument must provide  
22 that contested claims shall be valid and enforceable upon the final order of  
23 any court of competent jurisdiction in the United States. The trust must vest  
24 legal title to its assets in its trustees for the benefit of the assuming  
25 insurer's United States ceding insurers and their assigns and successors in  
26 interest. The trust and the assuming insurer are subject to examination as  
27 determined by the director. The trust must remain in effect for as long as  
28 the assuming insurer has outstanding obligations due under the reinsurance  
29 agreements subject to the trust.

30 (f) Not later than March 1 of each year, the trustees of each trust shall  
31 report to the director in writing the balance of the trust and listing the

1 trust's investments at the preceding year end, and shall certify the date of  
2 termination of the trust, if so planned, or certify that the trust will not ex-  
3 pire prior to the following December 31.

4 (7) Credit shall be allowed when the reinsurance is ceded to an assuming  
5 insurer not meeting the requirements of subsection (3), (4), (5) or (6) of this  
6 section, but only as to the insurance of risks located in jurisdictions in  
7 which the reinsurance is required by applicable law or regulation of that  
8 jurisdiction.

9 (8) If the assuming insurer is not authorized to transact insurance in this  
10 state or accredited as a reinsurer in this state, the director shall not allow  
11 the credit permitted by subsections (5) and (6) of this section unless the as-  
12 suming insurer agrees in the reinsurance agreement to the provisions stated  
13 in this subsection. This subsection is not intended to conflict with or over-  
14 ride the obligation of the parties to a reinsurance agreement to arbitrate  
15 their disputes, if such an obligation is created in the agreement. The as-  
16 suming insurer must agree in the reinsurance agreement:

17 (a) That in the event of the failure of the assuming insurer to perform its  
18 obligations under the terms of the reinsurance agreement, the assuming  
19 insurer, at the request of the ceding insurer, shall submit to the jurisdiction  
20 of any court of competent jurisdiction in any state of the United States, will  
21 comply with all requirements necessary to give the court jurisdiction and  
22 will abide by the final decision of the court or of any appellate court in the  
23 event of an appeal; and

24 (b) To designate the director or a designated attorney as its true and  
25 lawful attorney upon whom any lawful process in any action, suit or pro-  
26 ceeding instituted by or on behalf of the ceding company may be served.

27 **(9) Credit shall be allowed when the reinsurance is ceded to the**  
28 **Oregon Supplemental Reinsurance Program established in section 1**  
29 **of this 2013 Act.**

30 [(9)] (10) If the assuming insurer does not meet the requirements of sub-  
31 section (3), (4) or (5) of this section, the credit permitted by subsection (6)

1 of this section shall not be allowed unless the assuming insurer agrees in the  
2 trust agreements to the following conditions:

3 (a) Notwithstanding any other provisions in the trust instrument, if the  
4 trust fund is inadequate because it contains an amount less than the appli-  
5 cable amount required by subsection (6)(a), (b) or (c) of this section, or if the  
6 grantor of the trust has been declared insolvent or placed into receivership,  
7 rehabilitation, liquidation or similar proceedings under the laws of the  
8 grantor's state or country of domicile, the trustee shall comply with an order  
9 of the insurance commissioner with regulatory oversight over the trust or  
10 with an order of a court of competent jurisdiction directing the trustee to  
11 transfer to the insurance commissioner with regulatory oversight all the as-  
12 sets of the trust fund.

13 (b) The assets shall be distributed by and claims shall be filed with and  
14 valued by the insurance commissioner with regulatory oversight in accord-  
15 ance with the laws of the state in which the trust is domiciled that are ap-  
16 plicable to the liquidation of domestic insurance companies.

17 (c) If the insurance commissioner with regulatory oversight determines  
18 that the assets of the trust fund or any part thereof are not necessary to  
19 satisfy the claims of the United States ceding insurers of the grantor of the  
20 trust, the assets or part thereof shall be returned by the insurance commis-  
21 sioner according to the laws of that state and according to the terms of the  
22 trust agreement not inconsistent with the laws of that state.

23 (d) The grantor shall waive any right otherwise available to it under  
24 United States law that is inconsistent with this subsection.

25 **SECTION 6.** ORS 735.610 is amended to read:

26 735.610. (1) There is created in the Oregon Health Authority the Oregon  
27 Medical Insurance Pool Board. The board shall establish the Oregon Medical  
28 Insurance Pool and otherwise carry out the responsibilities of the board un-  
29 der ORS 735.600 to 735.650 **and sections 1, 2 and 4 of this 2013 Act.**

30 (2) The board shall consist of [10] 11 individuals, eight of whom shall be  
31 appointed by the Director of the Oregon Health Authority. The Director of

1 the Department of Consumer and Business Services or the director's designee  
 2 and the Director of the Oregon Health Authority or the director's designee  
 3 shall be members of the board. The chair of the board shall be elected from  
 4 among the members of the board. The board shall at all times, to the extent  
 5 possible, include at least one representative of a domestic insurance company  
 6 licensed to transact health insurance, one representative of a domestic not-  
 7 for-profit health care service contractor, one representative of a health  
 8 maintenance organization, one representative of reinsurers and [*two*] **three**  
 9 members of the general public who are not associated with the medical pro-  
 10 fession, a hospital or an insurer. **One of the members of the general**  
 11 **public must be a representative of business.** A majority of the voting  
 12 members of the board constitutes a quorum for the transaction of business.  
 13 An act by a majority of a quorum is an official act of the board.

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

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

19 (a) Enter into such contracts as are necessary or proper to carry out the  
 20 provisions and purposes of ORS 735.600 to 735.650 including the authority to  
 21 enter into contracts with similar pools of other states for the joint perform-  
 22 ance of common administrative functions, or with persons or other organ-  
 23 izations for the performance of administrative functions;

24 (b) Recover any assessments for, on behalf of, or against insurers;

25 (c) Take such legal action as is necessary to avoid the payment of im-  
 26 proper claims against the pool or the coverage provided by or through the  
 27 pool;

28 [*(d) Establish appropriate rates, rate schedules, rate adjustments, expense*  
 29 *allowances, insurance producers' referral fees, claim reserves or formulas and*  
 30 *perform any other actuarial function appropriate to the operation of the pool.*  
 31 *Rates may not be unreasonable in relation to the coverage provided, the risk*

1 *experience and expenses of providing the coverage. Rates and rate schedules*  
2 *may be adjusted for appropriate risk factors such as age and area variation*  
3 *in claim costs and shall take into consideration appropriate risk factors in*  
4 *accordance with established actuarial and underwriting practices;]*

5 [(e) Issue policies of insurance in accordance with the requirements of ORS  
6 735.600 to 735.650;]

7 [(f)] (d) Appoint from among insurers appropriate actuarial and other  
8 committees as necessary to provide technical assistance in the operation of  
9 the pool[, *policy and other contract design*] **and the Oregon Supplemental**  
10 **Reinsurance Program**, and **for** any other function within the authority of  
11 the board;

12 [(g)] (e) Seek advances to effect the purposes of the pool **and the pro-**  
13 **gram**; and

14 [(h)] (f) Establish rules, conditions and procedures for reinsuring risks  
15 under ORS 735.600 to 735.650 **and the operation of and participation of**  
16 **issuers of reinsurance eligible health benefit plans in the program.**

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

19 (6) The Director of the Oregon Health Authority shall adopt rules, as  
20 provided under ORS chapter 183, implementing policies recommended by the  
21 board for the purpose of carrying out ORS 735.600 to 735.650 **and sections**  
22 **1, 2 and 4 of this 2013 Act.**

23 (7) In consultation with the board, the Director of the Oregon Health  
24 Authority shall employ such staff and consultants as may be necessary for  
25 the purpose of carrying out responsibilities under ORS 735.600 to 735.650 **and**  
26 **sections 1, 2 and 4 of this 2013 Act.**

27 **SECTION 7.** ORS 735.630 is amended to read:

28 735.630. Neither participation in the **Oregon Medical Insurance Pool**  
29 **or the Oregon Supplemental Reinsurance Program** as members, the es-  
30 tablishment of rates, forms or procedures, nor any other action taken in the  
31 performance of the powers and duties under ORS 735.600 to 735.650 **and**

1 **sections 1, 2 and 4 of this 2013 Act**, shall be the basis of any legal action,  
2 criminal or civil liability or penalty against the Oregon Medical Insurance  
3 Pool Board, any members, the Director of the Oregon Health Authority, **the**  
4 **Director of the Department of Consumer and Business Services** or any  
5 of their agents or employees.

6 **SECTION 8.** ORS 735.635 is amended to read:

7 735.635. The **Oregon Medical Insurance** Pool established pursuant to  
8 ORS 735.600 to 735.650 **and the Oregon Supplemental Reinsurance Pro-**  
9 **gram established in section 1 of this 2013 Act** shall be exempt from any  
10 and all taxes assessed by the State of Oregon.

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### TERMINATION OF OREGON

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### MEDICAL INSURANCE POOL COVERAGE

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15 **SECTION 9.** ORS 291.055 is amended to read:

16 291.055. (1) Notwithstanding any other law that grants to a state agency  
17 the authority to establish fees, all new state agency fees or fee increases  
18 adopted during the period beginning on the date of adjournment sine die of  
19 a regular session of the Legislative Assembly and ending on the date of  
20 adjournment sine die of the next regular session of the Legislative Assembly:

21 (a) Are not effective for agencies in the executive department of govern-  
22 ment unless approved in writing by the Director of the Oregon Department  
23 of Administrative Services;

24 (b) Are not effective for agencies in the judicial department of govern-  
25 ment unless approved in writing by the Chief Justice of the Supreme Court;

26 (c) Are not effective for agencies in the legislative department of gov-  
27 ernment unless approved in writing by the President of the Senate and the  
28 Speaker of the House of Representatives;

29 (d) Shall be reported by the state agency to the Oregon Department of  
30 Administrative Services within 10 days of their adoption; and

31 (e) Are rescinded on adjournment sine die of the next regular session of

1 the Legislative Assembly as described in this subsection, unless otherwise  
2 authorized by enabling legislation setting forth the approved fees.

3 (2) This section does not apply to:

4 (a) Any tuition or fees charged by the State Board of Higher Education  
5 and the public universities listed in ORS 352.002.

6 (b) Taxes or other payments made or collected from employers for unem-  
7 ployment insurance required by ORS chapter 657 or premium assessments  
8 required by ORS 656.612 and 656.614 or contributions and assessments cal-  
9 culated by cents per hour for workers' compensation coverage required by  
10 ORS 656.506.

11 (c) Fees or payments required for:

12 (A) Health care services provided by the Oregon Health and Science  
13 University, by the Oregon Veterans' Homes and by other state agencies and  
14 institutions pursuant to ORS 179.610 to 179.770.

15 *[(B) Assessments and premiums paid to the Oregon Medical Insurance Pool*  
16 *established by ORS 735.614 and 735.625.]*

17 *[(C)] (B)* Copayments and premiums paid to the Oregon medical assistance  
18 program.

19 *[(D)] (C)* Assessments paid to the Department of Consumer and Business  
20 Services under ORS 743.951 and 743.961.

21 (d) Fees created or authorized by statute that have no established rate  
22 or amount but are calculated for each separate instance for each fee payer  
23 and are based on actual cost of services provided.

24 (e) State agency charges on employees for benefits and services.

25 (f) Any intergovernmental charges.

26 (g) Forest protection district assessment rates established by ORS 477.210  
27 to 477.265 and the Oregon Forest Land Protection Fund fees established by  
28 ORS 477.760.

29 (h) State Department of Energy assessments required by ORS 469.421 (8)  
30 and 469.681.

31 (i) Any charges established by the State Parks and Recreation Director

1 in accordance with ORS 565.080 (3).

2 (j) Assessments on premiums charged by the Department of Consumer and  
3 Business Services pursuant to ORS 731.804 or fees charged by the Division  
4 of Finance and Corporate Securities of the Department of Consumer and  
5 Business Services to banks, trusts and credit unions pursuant to ORS 706.530  
6 and 723.114.

7 (k) Public Utility Commission operating assessments required by ORS  
8 756.310 or charges paid to the Residential Service Protection Fund required  
9 by chapter 290, Oregon Laws 1987.

10 (L) Fees charged by the Housing and Community Services Department for  
11 intellectual property pursuant to ORS 456.562.

12 (m) New or increased fees that are anticipated in the legislative budgeting  
13 process for an agency, revenues from which are included, explicitly or im-  
14 plicitly, in the legislatively adopted budget or the legislatively approved  
15 budget for the agency.

16 (n) Tolls approved by the Oregon Transportation Commission pursuant to  
17 ORS 383.004.

18 (o) Convenience fees as defined in ORS 182.126 and established by the  
19 Oregon Department of Administrative Services under ORS 182.132 (3) and  
20 recommended by the Electronic Government Portal Advisory Board.

21 (3)(a) Fees temporarily decreased for competitive or promotional reasons  
22 or because of unexpected and temporary revenue surpluses may be increased  
23 to not more than their prior level without compliance with subsection (1)  
24 of this section if, at the time the fee is decreased, the state agency specifies  
25 the following:

26 (A) The reason for the fee decrease; and

27 (B) The conditions under which the fee will be increased to not more than  
28 its prior level.

29 (b) Fees that are decreased for reasons other than those described in  
30 paragraph (a) of this subsection may not be subsequently increased except  
31 as allowed by ORS 291.050 to 291.060 and 294.160.



1       **SECTION 10.** ORS 414.841 is amended to read:

2       414.841. For purposes of ORS 414.841 to 414.864:

3       (1) “Carrier” has the meaning given that term in ORS 735.700.

4       (2) “Dental plan” means a policy or certificate of group or individual  
5 health insurance, as defined in ORS 731.162, providing payment or re-  
6 imbursement only for the expenses of dental care.

7       (3) “Eligible individual” means an individual who:

8       (a) Is a resident of the State of Oregon;

9       (b) Is not eligible for Medicare;

10       (c) Is either:

11       (A) For health benefit plan coverage other than dental plans, a person  
12 who has been without health benefit plan coverage for a period of time es-  
13 tablished by the Office of Private Health Partnerships or meets exception  
14 criteria established by the office; or

15       (B) For dental plan coverage, an individual under 19 years of age who is  
16 uninsured or underinsured with respect to dental plan coverage;

17       (d) Except as otherwise provided by the office, has family income that is  
18 at or below 200 percent of the federal poverty level; and

19       (e) Meets other eligibility criteria established by the office.

20       (4) “Family” means an eligible individual and all other related individ-  
21 uals, as prescribed by the office by rule.

22       (5)(a) “Health benefit plan” means a policy or certificate of group or in-  
23 dividual health insurance, as defined in ORS 731.162, providing payment or  
24 reimbursement for hospital, medical and surgical expenses or for dental care  
25 expenses. “Health benefit plan” includes a health care service contractor or  
26 health maintenance organization subscriber contract[, *the Oregon Medical*  
27 *Insurance Pool*] and any plan provided by a less than fully insured multiple  
28 employer welfare arrangement or by another benefit arrangement defined in  
29 the federal Employee Retirement Income Security Act of 1974, as amended.

30       (b) “Health benefit plan” does not include coverage for accident only,  
31 specific disease or condition only, credit, disability income, coverage of

1 Medicare services pursuant to contracts with the federal government, Medi-  
2 care supplement insurance, student accident and health insurance, long term  
3 care insurance, hospital indemnity only, vision only, coverage issued as a  
4 supplement to liability insurance, insurance arising out of a workers' com-  
5 pensation or similar law, automobile medical payment insurance, insurance  
6 under which the benefits are payable with or without regard to fault and  
7 that is legally required to be contained in any liability insurance policy or  
8 equivalent self-insurance or coverage obtained or provided in another state  
9 but not available in Oregon.

10 (6) "Income" means gross income in cash or kind available to the appli-  
11 cant or the applicant's family. Income does not include earned income of the  
12 applicant's children or income earned by a spouse if there is a legal sepa-  
13 ration.

14 (7) "Resident" means an individual who meets the residency requirements  
15 established by rule by the office.

16 (8) "Subsidy" means payment or reimbursement to an eligible individual  
17 toward the purchase of a health benefit plan, and may include a net billing  
18 arrangement with carriers or a prospective or retrospective payment for  
19 health benefit plan premiums and eligible copayments or deductible expenses  
20 directly related to the eligible individual.

21 (9) "Third party administrator" means any insurance company or other  
22 entity licensed under the Insurance Code to administer health benefit plans.

23 **SECTION 11.** ORS 705.145 is amended to read:

24 705.145. (1) There is created in the State Treasury a fund to be known as  
25 the Consumer and Business Services Fund, separate and distinct from the  
26 General Fund. All moneys collected or received by the Department of Con-  
27 sumer and Business Services, except moneys [*collected pursuant to ORS*  
28 *735.612 and those moneys*] required to be paid into the Workers' Benefit Fund,  
29 shall be paid into the State Treasury and credited to the Consumer and  
30 Business Services Fund. Moneys in the fund may be invested in the same  
31 manner as other state moneys and any interest earned shall be credited to

1 the fund.

2 (2) The department shall keep a record of all moneys deposited in the  
3 Consumer and Business Services Fund that shall indicate, by separate ac-  
4 count, the source from which the moneys are derived, the interest earned and  
5 the activity or program against which any withdrawal is charged.

6 (3) If moneys credited to any one account are withdrawn, transferred or  
7 otherwise used for purposes other than the program or activity for which the  
8 account is established, interest shall accrue on the amount withdrawn from  
9 the date of withdrawal and until such funds are restored.

10 (4) Moneys in the fund are continuously appropriated to the department  
11 for its administrative expenses and for its expenses in carrying out its func-  
12 tions and duties under any provision of law.

13 (5) Except as provided in ORS 705.165, it is the intention of the Legisla-  
14 tive Assembly that the performance of the various duties and functions of  
15 the department in connection with each of its programs shall be financed by  
16 the fees, assessments and charges established and collected in connection  
17 with those programs.

18 (6) There is created by transfer from the Consumer and Business Services  
19 Fund a revolving administrative account in the amount of \$100,000. The re-  
20 volving account shall be disbursed by checks or orders issued by the director  
21 or the Workers' Compensation Board and drawn upon the State Treasury, to  
22 carry on the duties and functions of the department and the board. All  
23 checks or orders paid from the revolving account shall be reimbursed by a  
24 warrant drawn in favor of the department charged against the Consumer and  
25 Business Services Fund and recorded in the appropriate subsidiary record.

26 (7) For the purposes of ORS chapter 656, the revolving account created  
27 pursuant to subsection (6) of this section may also be used to:

28 (a) Pay compensation benefits; and

29 (b) Refund to employers amounts paid to the Consumer and Business  
30 Services Fund in excess of the amounts required by ORS chapter 656.

31 (8) Notwithstanding subsections (2), (3) and (5) of this section and except

1 as provided in ORS 455.220 (1), the moneys derived pursuant to ORS 446.003  
2 to 446.200, 446.210, 446.225 to 446.285, 446.395 to 446.420, 446.566 to 446.646,  
3 446.661 to 446.756 and 455.220 (1) and deposited to the fund, interest earned  
4 on those moneys and withdrawals of moneys for activities or programs under  
5 ORS 446.003 to 446.200, 446.210, 446.225 to 446.285, 446.395 to 446.420, 446.566  
6 to 446.646 and 446.661 to 446.756, or education and training programs per-  
7 taining thereto, must be assigned to a single account within the fund.

8 (9) Notwithstanding subsections (2), (3) and (5) of this section, the moneys  
9 derived pursuant to ORS 455.240 or 460.370 or from state building code or  
10 specialty code program fees for which the amount is established by depart-  
11 ment rule pursuant to ORS 455.020 (2) and deposited to the fund, interest  
12 earned on those moneys and withdrawals of moneys for activities or pro-  
13 grams described under ORS 455.240 or 446.566 to 446.646, 446.661 to 446.756  
14 and 460.310 to 460.370, structural or mechanical specialty code programs or  
15 activities for which a fee is collected under ORS 455.020 (2), or programs  
16 described under subsection (10) of this section that provide training and ed-  
17 ucation for persons employed in producing, selling, installing, delivering or  
18 inspecting manufactured structures or manufactured dwelling parks or re-  
19 creation parks, must be assigned to a single account within the fund.

20 (10) Notwithstanding ORS 279.835 to 279.855 and ORS chapters 279A and  
21 279B, the department may, after consultation with the appropriate specialty  
22 code advisory boards established under ORS 455.132, 455.135, 455.138, 480.535  
23 and 693.115, contract for public or private parties to develop or provide  
24 training and education programs relating to the state building code and as-  
25 sociated licensing or certification programs.

26 **SECTION 12.** ORS 731.036 is amended to read:

27 731.036. Except as provided in ORS 743.061 or as specifically provided by  
28 law, the Insurance Code does not apply to any of the following to the extent  
29 of the subject matter of the exemption:

- 30 (1) A bail bondsman, other than a corporate surety and its agents.  
31 (2) A fraternal benefit society that has maintained lodges in this state and

1 other states for 50 years prior to January 1, 1961, and for which a certificate  
2 of authority was not required on that date.

3 (3) A religious organization providing insurance benefits only to its em-  
4 ployees, if the organization is in existence and exempt from taxation under  
5 section 501(c)(3) of the federal Internal Revenue Code on September 13, 1975.

6 (4) Public bodies, as defined in ORS 30.260, that either individually or  
7 jointly establish a self-insurance program for tort liability in accordance  
8 with ORS 30.282.

9 (5) Public bodies, as defined in ORS 30.260, that either individually or  
10 jointly establish a self-insurance program for property damage in accordance  
11 with ORS 30.282.

12 (6) Cities, counties, school districts, community college districts, commu-  
13 nity college service districts or districts, as defined in ORS 198.010 and  
14 198.180, that either individually or jointly insure for health insurance cov-  
15 erage, excluding disability insurance, their employees or retired employees,  
16 or their dependents, or students engaged in school activities, or combination  
17 of employees and dependents, with or without employee or student contribu-  
18 tions, if all of the following conditions are met:

19 (a) The individual or jointly self-insured program meets the following  
20 minimum requirements:

21 (A) In the case of a school district, community college district or com-  
22 munity college service district, the number of covered employees and depen-  
23 dents and retired employees and dependents aggregates at least 500  
24 individuals;

25 (B) In the case of an individual public body program other than a school  
26 district, community college district or community college service district, the  
27 number of covered employees and dependents and retired employees and de-  
28 pendants aggregates at least 500 individuals; and

29 (C) In the case of a joint program of two or more public bodies, the  
30 number of covered employees and dependents and retired employees and de-  
31 pendants aggregates at least 1,000 individuals;

1 (b) The individual or jointly self-insured health insurance program in-  
2 cludes all coverages and benefits required of group health insurance policies  
3 under ORS chapters 743 and 743A;

4 (c) The individual or jointly self-insured program must have program  
5 documents that define program benefits and administration;

6 (d) Enrollees must be provided copies of summary plan descriptions in-  
7 cluding:

8 (A) Written general information about services provided, access to ser-  
9 vices, charges and scheduling applicable to each enrollee's coverage;

10 (B) The program's grievance and appeal process; and

11 (C) Other group health plan enrollee rights, disclosure or written proce-  
12 dure requirements established under ORS chapters 743 and 743A;

13 (e) The financial administration of an individual or jointly self-insured  
14 program must include the following requirements:

15 (A) Program contributions and reserves must be held in separate accounts  
16 and used for the exclusive benefit of the program;

17 (B) The program must maintain adequate reserves. Reserves may be in-  
18 vested in accordance with the provisions of ORS chapter 293. Reserve ade-  
19 quacy must be calculated annually with proper actuarial calculations  
20 including the following:

21 (i) Known claims, paid and outstanding;

22 (ii) A history of incurred but not reported claims;

23 (iii) Claims handling expenses;

24 (iv) Unearned contributions; and

25 (v) A claims trend factor; and

26 (C) The program must maintain adequate reinsurance against the risk of  
27 economic loss in accordance with the provisions of ORS 742.065 unless the  
28 program has received written approval for an alternative arrangement for  
29 protection against economic loss from the Director of the Department of  
30 Consumer and Business Services;

31 (f) The individual or jointly self-insured program must have sufficient

1 personnel to service the employee benefit program or must contract with a  
2 third party administrator licensed under ORS chapter 744 as a third party  
3 administrator to provide such services;

4 [(g) *The individual or jointly self-insured program shall be subject to as-*  
5 *essment in accordance with ORS 735.614 and former enrollees shall be eligible*  
6 *for portability coverage in accordance with ORS 735.616;*]

7 [(h)] (g) The public body, or the program administrator in the case of a  
8 joint insurance program of two or more public bodies, files with the Director  
9 of the Department of Consumer and Business Services copies of all docu-  
10 ments creating and governing the program, all forms used to communicate  
11 the coverage to beneficiaries, the schedule of payments established to support  
12 the program and, annually, a financial report showing the total incurred cost  
13 of the program for the preceding year. A copy of the annual audit required  
14 by ORS 297.425 may be used to satisfy the financial report filing requirement;  
15 and

16 [(i)] (h) Each public body in a joint insurance program is liable only to  
17 its own employees and no others for benefits under the program in the event,  
18 and to the extent, that no further funds, including funds from insurance  
19 policies obtained by the pool, are available in the joint insurance pool.

20 (7) All ambulance services.

21 (8) A person providing any of the services described in this subsection.  
22 The exemption under this subsection does not apply to an authorized insurer  
23 providing such services under an insurance policy. This subsection applies  
24 to the following services:

25 (a) Towing service.

26 (b) Emergency road service, which means adjustment, repair or replace-  
27 ment of the equipment, tires or mechanical parts of a motor vehicle in order  
28 to permit the motor vehicle to be operated under its own power.

29 (c) Transportation and arrangements for the transportation of human re-  
30 mains, including all necessary and appropriate preparations for and actual  
31 transportation provided to return a decedent's remains from the decedent's

1 place of death to a location designated by a person with valid legal authority  
2 under ORS 97.130.

3 (9)(a) A person described in this subsection who, in an agreement to lease  
4 or to finance the purchase of a motor vehicle, agrees to waive for no addi-  
5 tional charge the amount specified in paragraph (b) of this subsection upon  
6 total loss of the motor vehicle because of physical damage, theft or other  
7 occurrence, as specified in the agreement. The exemption established in this  
8 subsection applies to the following persons:

9 (A) The seller of the motor vehicle, if the sale is made pursuant to a  
10 motor vehicle retail installment contract.

11 (B) The lessor of the motor vehicle.

12 (C) The lender who finances the purchase of the motor vehicle.

13 (D) The assignee of a person described in this paragraph.

14 (b) The amount waived pursuant to the agreement shall be the difference,  
15 or portion thereof, between the amount received by the seller, lessor, lender  
16 or assignee, as applicable, that represents the actual cash value of the motor  
17 vehicle at the date of loss, and the amount owed under the agreement.

18 (10) A self-insurance program for tort liability or property damage that  
19 is established by two or more affordable housing entities and that complies  
20 with the same requirements that public bodies must meet under ORS 30.282  
21 (6). As used in this subsection:

22 (a) "Affordable housing" means housing projects in which some of the  
23 dwelling units may be purchased or rented, with or without government as-  
24 sistance, on a basis that is affordable to individuals of low income.

25 (b) "Affordable housing entity" means any of the following:

26 (A) A housing authority created under the laws of this state or another  
27 jurisdiction and any agency or instrumentality of a housing authority, in-  
28 cluding but not limited to a legal entity created to conduct a self-insurance  
29 program for housing authorities that complies with ORS 30.282 (6).

30 (B) A nonprofit corporation that is engaged in providing affordable  
31 housing.



1 (C) A partnership or limited liability company that is engaged in provid-  
2 ing affordable housing and that is affiliated with a housing authority de-  
3 scribed in subparagraph (A) of this paragraph or a nonprofit corporation  
4 described in subparagraph (B) of this paragraph if the housing authority or  
5 nonprofit corporation:

6 (i) Has, or has the right to acquire, a financial or ownership interest in  
7 the partnership or limited liability company;

8 (ii) Has the power to direct the management or policies of the partnership  
9 or limited liability company;

10 (iii) Has entered into a contract to lease, manage or operate the afforda-  
11 ble housing owned by the partnership or limited liability company; or

12 (iv) Has any other material relationship with the partnership or limited  
13 liability company.

14 (11) A community-based health care initiative approved by the Adminis-  
15 trator of the Office for Oregon Health Policy and Research under ORS  
16 735.723 operating a community-based health care improvement program ap-  
17 proved by the administrator.

18 (12) Except as provided in ORS 735.500 and 735.510, a person certified by  
19 the Department of Consumer and Business Services to operate a retainer  
20 medical practice.

21 **SECTION 13.** ORS 734.790 is amended to read:

22 734.790. (1) ORS 734.750 to 734.890 provide coverage for policies and con-  
23 tracts specified in subsection (2) of this section to the following persons who  
24 are not provided coverage under the laws of another state:

25 (a) To a person who is a resident, if the person is an owner of or a cer-  
26 tificate holder under the policy or contract other than a structured settle-  
27 ment annuity or, in the case of an unallocated annuity contract, an employee  
28 participating in a governmental retirement plan established under section  
29 401, 403(b) or 457 of the United States Internal Revenue Code or the benefi-  
30 ciaries of each such individual if deceased.

31 (b) To a person who is not a resident, if the person is an owner of or a

1 certificate holder under the policy or contract other than a structured  
2 settlement annuity or, in the case of an unallocated annuity contract, an  
3 employee participating in a governmental retirement plan established under  
4 section 401, 403(b) or 457 of the United States Internal Revenue Code or the  
5 beneficiaries of each such individual if deceased. This paragraph applies to  
6 a person who is not a resident only if all of the following conditions are met:

7 (A) The insurer that issued the policy or contract must be a member  
8 insurer.

9 (B) The state in which the person resides must have an association simi-  
10 lar to the Oregon Life and Health Insurance Guaranty Association.

11 (C) The person must not be eligible for coverage by an association in the  
12 state in which the person resides, as described in subparagraph (B) of this  
13 paragraph, due to the fact that the insurer was not authorized to transact  
14 insurance or licensed in that state at the time specified in the state's guar-  
15 anty association law.

16 (c) To a person who, regardless of where the person resides, is a benefi-  
17 ciary, assignee or payee of the persons covered under paragraph (a) or (b)  
18 of this subsection. This paragraph does not include a nonresident certificate  
19 holder under a group policy or contract.

20 (d) To a person who is a payee under a structured settlement annuity, or  
21 to the beneficiary of a payee if the payee is deceased, if the payee:

22 (A) Is a resident, regardless of where the contract owner resides; or

23 (B) Is not a resident, but only under both of the following conditions:

24 (i) The contract owner of the structured settlement annuity is a resident  
25 and is not afforded any coverage by an association in another state that is  
26 similar to the association created under ORS 734.800, or the contract owner  
27 of the structured settlement annuity is not a resident but the insurer that  
28 issued the structured settlement annuity is domiciled in this state and the  
29 state in which the contract owner resides has an association similar to the  
30 association created under ORS 734.800; and

31 (ii) Neither the payee or beneficiary nor the contract owner of the

1 structured settlement annuity is eligible for coverage by the association of  
2 the state in which the payee or contract owner resides.

3 (2) Except as limited by ORS 734.750 to 734.890, the association shall  
4 provide coverage to the persons specified in subsection (1) of this section for  
5 direct nongroup life or health insurance policies or annuity contracts, for  
6 certificates under direct group policies or contracts, and for supplemental  
7 contracts to any of these, in each case issued by member insurers.

8 (3) ORS 734.750 to 734.890 do not provide coverage for:

9 (a) That portion of any policy or contract not guaranteed by the member  
10 insurer or under which the risk is borne by the policyholder or contract  
11 owner.

12 (b) Any policy or contract or part thereof assumed by the impaired or  
13 insolvent insurer under a contract of reinsurance, other than reinsurance for  
14 which assumption certificates have been issued.

15 (c) Any policy or contract issued by a health care service contractor  
16 complying with ORS 750.005 to 750.095.

17 (d) Any policy or contract issued by a fraternal benefit society.

18 (e) Any portion of a policy or contract to the extent that the interest rate  
19 on which the policy or contract is based, or to the extent that the interest  
20 rate, crediting rate or similar factor determined by use of an index or other  
21 external reference stated in the policy or contract for the purpose of calcu-  
22 lating returns or changes in value:

23 (A) Exceeds, when averaged over the period of four years prior to the date  
24 on which the member insurer becomes either an impaired or insolvent  
25 insurer under ORS 734.750 to 734.890, whichever occurs first, a rate of in-  
26 terest determined by subtracting four percentage points from Moody's Cor-  
27 porate Bond Yield Average averaged for that same four-year period or for a  
28 lesser period if the policy or contract was issued less than four years before  
29 the member insurer becomes either an impaired or insolvent insurer under  
30 ORS 734.750 to 734.890, whichever occurred first; and

31 (B) Exceeds, on and after the date on which the member insurer becomes

1 either an impaired or insolvent insurer under ORS 734.750 to 734.890,  
2 whichever occurs first, the rate of interest determined by subtracting three  
3 percentage points from Moody's Corporate Bond Yield Average as most re-  
4 cently available.

5 (f) Any portion of a policy or contract issued to a plan or program of an  
6 employer, association or similar entity to provide life insurance, health in-  
7 surance or annuity benefits to its employees or members to the extent that  
8 the plan or program is self-funded or uninsured, including benefits payable  
9 by an employer, association or similar entity under any of the following:

10 (A) A multiple employer welfare arrangement as defined in section 3(40)  
11 (29 U.S.C. 1002(40)) of the Employee Retirement Income Security Act of 1974,  
12 as amended.

13 (B) A minimum premium group insurance plan.

14 (C) A stop-loss group insurance plan.

15 (D) An administrative services only contract.

16 (g) Any portion of a policy or contract to the extent that it provides  
17 dividends or experience rating credits or voting rights, or provides that any  
18 fees or allowances be paid to any person, including the policyholder or con-  
19 tract owner, in connection with the service to or administration of the policy  
20 or contract.

21 (h) Any policy or contract issued in this state by a member insurer at a  
22 time that the insurer did not have a certificate of authority to issue the  
23 policy or contract in this state.

24 (i) Any unallocated annuity contract issued to or in connection with an  
25 employee benefit plan protected under the federal Pension Benefit Guaranty  
26 Corporation, regardless of whether the federal Pension Benefit Guaranty  
27 Corporation has yet become liable to make any payments with respect to the  
28 benefit plan.

29 (j) Any portion of any unallocated annuity contract that is not issued to  
30 or in connection with a government retirement plan referred to in subsection  
31 (1) of this section, or a government lottery.

1     ~~[(k)]~~ *Any coverage issued by the Oregon Medical Insurance Pool.*]

2     ~~[(L)]~~ **(k)** Any portion of a policy or contract to the extent that the as-  
3     sessments required by ORS 734.815 with respect to the policy or contract are  
4     preempted by federal or state law.

5     ~~[(m)]~~ **(L)** An obligation that does not arise under the express written  
6     terms of the policy or contract issued by the insurer to the policyholder or  
7     contract owner, including but not limited to:

8         **(A)** Claims based on marketing materials;

9         **(B)** Claims based on side letters, riders or other documents that were is-  
10     sued by the insurer without meeting applicable policy or contract form filing  
11     or approval requirements;

12         **(C)** Misrepresentations of, or regarding, policy or contract benefits;

13         **(D)** Extracontractual claims, including but not limited to claims related  
14     to bad faith in the payment of claims, punitive or exemplary damages or at-  
15     torney fees or costs; or

16         **(E)** A claim for penalties or consequential or incidental damages.

17     ~~[(n)]~~ **(m)** A contractual agreement that establishes the member insurer's  
18     obligations to provide a book value accounting guaranty for defined contri-  
19     bution benefit plan participants by reference to a portfolio of assets that is  
20     owned by the benefit plan or its trustee that in either case is not an affiliate  
21     of the member insurer.

22     ~~[(o)]~~ **(n)** Any portion of a policy or contract to the extent that portion  
23     provides for interest or other changes in value to be determined by the use  
24     of an index or other external reference stated in the policy or contract, but  
25     the changes in value have not been credited to the policy or contract, or as  
26     to which the policyholder's or contract owner's rights are subject to forfei-  
27     ture, as of the date on which the member insurer becomes either an impaired  
28     or insolvent insurer, whichever occurs first. If the interest or changes in  
29     value in a policy or contract are credited less frequently than annually, for  
30     purposes of determining the values that have been credited and are not sub-  
31     ject to forfeiture under this paragraph, the interest or change in value that

1 is determined by using the procedures specified in the policy or contract  
2 shall be credited as if the contractual date of crediting interest or changing  
3 value was the date of the impairment or insolvency, whichever is earlier, and  
4 may not be subject to forfeiture.

5 [(p)] (o) Any policy or contract providing any hospital, medical, pre-  
6 scription drug or other health care benefits under Part C or Part D of sub-  
7 chapter XVIII, chapter 7, Title 42 of the United States Code, or any  
8 regulations issued under those provisions.

9 (4) As used in this section, “Moody’s Corporate Bond Yield Average”  
10 means the Monthly Average Corporates as published by Moody’s Investors  
11 Service, Inc., or any successor thereto.

12 **SECTION 14.** ORS 735.612 is amended to read:

13 735.612. (1) There is established in the State Treasury, the Oregon Medical  
14 Insurance Pool Account, which shall consist of:

15 (a) Moneys appropriated to the account by the Legislative Assembly [*to*  
16 *obtain the coverage described in ORS 735.625*].

17 (b) Interest earnings from the investment of moneys in the account.

18 (c) Assessments and other revenues collected or received by the Oregon  
19 Medical Insurance Pool Board.

20 (2) All moneys in the Oregon Medical Insurance Pool Account are con-  
21 tinuously appropriated to the Oregon Medical Insurance Pool Board to carry  
22 out the provisions of ORS 735.600 to 735.650.

23 (3) The Oregon Medical Insurance Pool Board shall transfer to the  
24 Oregon Health Authority Fund established in ORS 413.101 an amount equal  
25 to the operating budget authorized by the Legislative Assembly or as that  
26 budget may be modified by the Emergency Board or the Oregon Department  
27 of Administrative Services, for operation of the Oregon Medical Insurance  
28 Pool Board.

29 **SECTION 15.** ORS 735.616 is amended to read:

30 735.616. (1) An applicant may qualify for portability health insurance  
31 coverage under the Oregon Medical Insurance Pool if:

1 (a) An application for coverage is made not later than the 63rd day after  
2 the date of first eligibility **and is made before December 1, 2013**; and

3 (b) The individual is an Oregon resident at the time of the application.

4 (2) In addition to individuals otherwise qualified under ORS 735.615, the  
5 following individuals qualify for portability health insurance coverage under  
6 the Oregon Medical Insurance Pool:

7 (a) An individual who has left coverage that was in effect for a minimum  
8 of 180 consecutive days under one or more group health benefit plans, if the  
9 terminated coverage was in a plan issued or established in a state other than  
10 Oregon;

11 (b) An eligible individual, as defined in ORS 743.760, who has left cover-  
12 age under a group health benefit plan or a portability health benefit plan  
13 and whose carrier cannot offer a portability plan under ORS 743.760 (6) be-  
14 cause of:

15 (A) A change in residence of the eligible individual within Oregon;

16 (B) A change in the geographic area served by the group carrier; or

17 (C) The carrier's withdrawal from the group market in Oregon in ac-  
18 cordance with ORS 743.737 and 743.754;

19 (c) An individual who has left coverage that was in effect for an unin-  
20 terrupted period of 180 days or more under one or more Oregon group health  
21 benefit plans and the terminated coverage was provided by:

22 (A) An employee welfare benefit plan that is exempt from state regulation  
23 under the federal Employee Retirement Income Security Act of 1974, as  
24 amended;

25 (B) A multiple employer welfare arrangement subject to ORS 750.301 to  
26 750.341; or

27 (C) A public body of this state in accordance with ORS 731.036; and

28 (d) On or after January 1, 1998, an individual who meets the eligibility  
29 requirements of 42 U.S.C. 300gg-41, as amended and in effect on January 1,  
30 1998, and does not otherwise qualify to obtain portability coverage from an  
31 Oregon group carrier in accordance with ORS 743.760.

1 (3) Eligibility for coverage pursuant to subsections (1) and (2) of this  
2 section is subject to the following provisions:

3 (a) An eligible individual does not include:

4 (A) An individual who remains eligible for the individual's prior group  
5 coverage or would remain eligible for prior group coverage in a plan under  
6 the federal Employee Retirement Income Security Act of 1974, as amended,  
7 were it not for action by the plan sponsor relating to the actual or expected  
8 health condition of the individual;

9 (B) An individual who is covered under another health benefit plan at the  
10 time that portability coverage would commence;

11 (C) An individual who is eligible to enroll in another health benefit plan  
12 offered by the employer, other than as a late enrollee, at the time that por-  
13 tability coverage would commence; or

14 (D) An individual who is eligible for the federal Medicare program.

15 (b) If an eligible individual has left group coverage issued by an insurance  
16 company, a health care service contractor or a health maintenance organ-  
17 ization, the date of first eligibility is the day following the termination date  
18 of the group coverage, including any period of continuation coverage that  
19 was elected by the individual under federal law or under ORS 743.600 or  
20 743.610.

21 (c) If an eligible individual has left group coverage issued by an entity  
22 other than an insurance company, a health care service contractor or a  
23 health maintenance organization, the date of first eligibility is the day fol-  
24 lowing the termination date of the group coverage, including the full extent  
25 of continuation coverage available to the individual under federal law and  
26 ORS 743.600 and 743.610.

27 (d) If an individual is eligible for coverage pursuant to subsection (2)(b)  
28 of this section, the date of first eligibility is the day following the loss of the  
29 group or portability coverage.

30 (4) Coverage under the Oregon Medical Insurance Pool pursuant to sub-  
31 sections (1) and (2) of this section shall be offered according to the following



1 provisions:

2 (a) Coverage is subject to ORS 743.760 (2) and (8);

3 (b) Coverage may not be subject to a preexisting conditions provision,  
4 exclusion period, waiting period, residency period or other similar limitation  
5 on coverage; and

6 (c) The individual shall be required to pay a premium rate not more than  
7 the applicable portability risk rate determined by the Oregon Medical In-  
8 surance Pool Board pursuant to ORS 735.625.

9 **SECTION 16.** ORS 735.625 is amended to read:

10 735.625. (1) Except as provided in subsection (3)(c) of this section, the  
11 Oregon Medical Insurance Pool Board shall offer major medical expense  
12 coverage to every eligible person **until December 31, 2013.**

13 (2) The coverage to be issued by the board, its schedule of benefits, ex-  
14 clusions and other limitations, shall be established through rules adopted by  
15 the board, taking into consideration the advice and recommendations of the  
16 pool members. In the absence of such rules, the pool shall adopt by rule the  
17 minimum benefits prescribed by section 6 (Alternative 1) of the Model Health  
18 Insurance Pooling Mechanism Act of the National Association of Insurance  
19 Commissioners (1984).

20 (3)(a) In establishing portability coverage under the pool, the board shall  
21 consider the levels of medical insurance provided in this state and medical  
22 economic factors identified by the board. The board may adopt rules to es-  
23 tablish benefit levels, deductibles, coinsurance factors, exclusions and limi-  
24 tations that the board determines are equivalent to the portability health  
25 benefit plans established under ORS 743.760.

26 (b) In establishing medical insurance coverage under the pool, the board  
27 shall consider the levels of medical insurance provided in this state and  
28 medical economic factors identified by the board. The board may adopt rules  
29 to establish benefit levels, deductibles, coinsurance factors, exclusions and  
30 limitations that the board determines are equivalent to those found in the  
31 commercial group or employer-based medical insurance market.

1 (c) The board may provide a separate Medicare supplement policy for in-  
2 dividuals under the age of 65 who are receiving Medicare disability benefits.  
3 The board shall adopt rules to establish benefits, deductibles, coinsurance,  
4 exclusions and limitations, premiums and eligibility requirements for the  
5 Medicare supplement policy.

6 (d) In establishing medical insurance coverage for persons eligible for  
7 coverage under ORS 735.615 (1)(d), the board shall consider the levels of  
8 medical insurance provided in this state and medical economic factors iden-  
9 tified by the board. The board may adopt rules to establish benefit levels,  
10 deductibles, coinsurance factors, exclusions and limitations to create benefit  
11 plans that qualify the person for the credit for health insurance costs under  
12 section 35 of the federal Internal Revenue Code, as amended and in effect  
13 on December 31, 2004.

14 (4)(a) Premiums charged for coverages issued by the board may not be  
15 unreasonable in relation to the benefits provided, the risk experience and the  
16 reasonable expenses of providing the coverage.

17 (b) Separate schedules of premium rates based on age and geographical  
18 location may apply for individual risks.

19 (c) The board shall determine the applicable medical and portability risk  
20 rates either by calculating the average rate charged by insurers offering  
21 coverages in the state comparable to the pool coverage or by using reason-  
22 able actuarial techniques. The risk rates shall reflect anticipated experience  
23 and expenses for such coverage. Rates for pool coverage may not be more  
24 than 125 percent of rates established as applicable for medically eligible in-  
25 dividuals or for persons eligible for pool coverage under ORS 735.615 (1)(d),  
26 or 100 percent of rates established as applicable for portability eligible indi-  
27 viduals.

28 (d) The board shall annually determine adjusted benefits and premiums.  
29 The adjustments shall be in keeping with the purposes of ORS 735.600 to  
30 735.650, subject to a limitation of keeping pool losses under one percent of  
31 the total of all medical insurance premiums, subscriber contract charges and

1 110 percent of all benefits paid by member self-insurance arrangements. The  
2 board may determine the total number of persons that may be enrolled for  
3 coverage at any time and may permit and prohibit enrollment in order to  
4 maintain the number authorized. Nothing in this paragraph authorizes the  
5 board to prohibit enrollment for any reason other than to control the number  
6 of persons in the pool.

7 (5)(a) The board may apply:

8 (A) A waiting period of not more than 90 days during which the person  
9 has no available coverage; or

10 (B) Except as provided in paragraph (c) of this subsection, a preexisting  
11 conditions provision of not more than six months from the effective date of  
12 coverage under the pool.

13 (b) In determining whether a preexisting conditions provision applies to  
14 an eligible enrollee, except as provided in this subsection, the board shall  
15 credit the time the eligible enrollee was covered under a previous health  
16 benefit plan if the previous health benefit plan was continuous to a date not  
17 more than 63 days prior to the effective date of the new coverage under the  
18 Oregon Medical Insurance Pool, exclusive of any applicable waiting period.  
19 The Oregon Medical Insurance Pool Board need not credit the time for pre-  
20 vious coverage to which the insured or dependent is otherwise entitled under  
21 this subsection with respect to benefits and services covered in the pool  
22 coverage that were not covered in the previous coverage.

23 (c) The board may adopt rules applying a preexisting conditions provision  
24 to a person who is eligible for coverage under ORS 735.615 (1)(d).

25 (d) For purposes of this subsection, a “preexisting conditions provision”  
26 means a provision that excludes coverage for services, charges or expenses  
27 incurred during a specified period not to exceed six months following the  
28 insured’s effective date of coverage, for a condition for which medical advice,  
29 diagnosis, care or treatment was recommended or received during the six-  
30 month period immediately preceding the insured’s effective date of coverage.

31 (6)(a) Benefits otherwise payable under pool coverage shall be reduced by

1 all amounts paid or payable through any other health insurance, or self-  
2 insurance arrangement, and by all hospital and medical expense benefits paid  
3 or payable under any workers' compensation coverage, automobile medical  
4 payment or liability insurance whether provided on the basis of fault or  
5 nonfault, and by any hospital or medical benefits paid or payable under or  
6 provided pursuant to any state or federal law or program except the  
7 Medicaid portion of the medical assistance program offering a level of health  
8 services described in ORS 414.707.

9 (b) The board shall have a cause of action against an eligible person for  
10 the recovery of the amount of benefits paid which are not for covered ex-  
11 penses. Benefits due from the pool may be reduced or refused as a setoff  
12 against any amount recoverable under this paragraph.

13 (7) Except as provided in ORS 735.616, no mandated benefit statutes apply  
14 to pool coverage under ORS 735.600 to 735.650.

15 (8) Pool coverage may be furnished through a health care service con-  
16 tractor or such alternative delivery system as will contain costs while  
17 maintaining quality of care.

18 **SECTION 17.** ORS 735.645 is amended to read:

19 735.645. Every insurer shall include a notice of the existence of the  
20 Oregon Medical Insurance Pool in any adverse underwriting decision, **issued**  
21 **on or before November 30, 2013**, on individual medical insurance for rea-  
22 sons of the health of the applicant, as described in ORS 735.615 (1)(a).

23 **SECTION 18.** ORS 735.650 is amended to read:

24 735.650. [(1)] The following provisions of the Insurance Code shall apply  
25 to the pool to the extent applicable and not inconsistent with the express  
26 provisions of ORS 735.600 to 735.650: ORS 731.004 to 731.022, 731.052 to  
27 731.146, 731.162, 731.216 to 731.328, 742.023, 742.028, 742.046, 742.051, 742.056,  
28 743.024, 743.027, 743.028, 743.041, 743.050, 743.100 to 743.106, 743.402, 743.801,  
29 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819,  
30 743.821, 743.823, 743.827, 743.829, 743.834, 743.837, 743.839, 743.845, 743A.084,  
31 743A.090, 746.005 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615,

1 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and  
2 746.690.

3 *[(2) For the purposes of this section only, the pool shall be deemed an*  
4 *insurer, pool coverage shall be deemed individual health insurance and pool*  
5 *coverage contracts shall be deemed policies.]*

6 **SECTION 19.** ORS 743.402 is amended to read:

7 743.402. Nothing in ORS 743.405 to 743.498, 743A.160 and 743A.164 shall  
8 apply to or affect:

9 (1) Any workers' compensation insurance policy or any liability insurance  
10 policy with or without supplementary expense coverage therein;

11 (2) Any policy of reinsurance;

12 (3) Any blanket or group policy of insurance; or

13 (4) Any life insurance policy, or policy supplemental thereto which con-  
14 tains only such provisions relating to health insurance as:

15 (a) Provide additional benefits in case of death or dismemberment or loss  
16 of sight by accident; or

17 (b) Operate to safeguard such policy against lapse, or to give a special  
18 surrender value or special benefit or an annuity in the event the insured  
19 shall become totally and permanently disabled, as defined by the policy or  
20 supplemental policy.

21 *[(5) Coverage under ORS 735.600 to 735.650.]*

22 **SECTION 20.** ORS 743.730, as amended by section 49, chapter 500, Oregon  
23 Laws 2011, and section 20, chapter 38, Oregon Laws 2012, is amended to read:

24 743.730. For purposes of ORS 743.730 to 743.773:

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

1 plans.

2 (2) "Affiliate" of, or person "affiliated" with, a specified person means any  
3 carrier who, directly or indirectly through one or more intermediaries, con-  
4 trols or is controlled by or is under common control with a specified person.  
5 For purposes of this definition, "control" has the meaning given that term  
6 in ORS 732.548.

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

9 (a) That is applied uniformly and without regard to any health status  
10 related factors to an enrollee or late enrollee in lieu of a preexisting condi-  
11 tion exclusion;

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

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

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

19 (4) "Basic health benefit plan" means a health benefit plan that provides  
20 bronze plan coverage and that is approved by the Department of Consumer  
21 and Business Services under ORS 743.736.

22 (5) "Bona fide association" means an association that meets the require-  
23 ments of 42 U.S.C. 300gg-91 as amended and in effect on March 23, 2010.

24 (6) "Bronze plan" means a health benefit plan that meets the criteria for  
25 a bronze plan prescribed by the director by rule pursuant to ORS 743.822 (2).

26 (7) "Carrier," except as provided in ORS 743.760, means any person who  
27 provides health benefit plans in this state, including:

28 (a) A licensed insurance company;

29 (b) A health care service contractor;

30 (c) A health maintenance organization;

31 (d) An association or group of employers that provides benefits by means

1 of a multiple employer welfare arrangement and that:

2 (A) Is subject to ORS 750.301 to 750.341; or

3 (B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects  
4 to be governed by ORS 743.733 to 743.737; or

5 (e) Any other person or corporation responsible for the payment of bene-  
6 fits or provision of services.

7 (8) "Catastrophic plan" means a health benefit plan that meets the re-  
8 quirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is of-  
9 fered through the Oregon Health Insurance Exchange.

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

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

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

22 (12) "Employee" means any individual employed by an employer.

23 (13) "Enrollee" means an employee, dependent of the employee or an in-  
24 dividual otherwise eligible for a group, individual or portability health ben-  
25 efit plan who has enrolled for coverage under the terms of the plan.

26 (14) "Exchange" means the health insurance exchange administered by the  
27 Oregon Health Insurance Exchange Corporation in accordance with ORS  
28 741.310.

29 (15) "Exclusion period" means a period during which specified treatments  
30 or services are excluded from coverage.

31 (16) "Financial impairment" means that a carrier is not insolvent and is:

1 (a) Considered by the director to be potentially unable to fulfill its con-  
2 tractual obligations; or

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

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

8 (A) Group health benefit plans offered to small employers;

9 (B) Individual health benefit plans; or

10 (C) Portability health benefit plans.

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

13 (18) "Grandfathered health plan" has the meaning prescribed by the  
14 United States Secretaries of Labor, Health and Human Services and the  
15 Treasury pursuant to 42 U.S.C. 18011(e).

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

19 (20)(a) "Health benefit plan" means any:

20 (A) Hospital expense, medical expense or hospital or medical expense  
21 policy or certificate;

22 (B) Health care service contractor or health maintenance organization  
23 subscriber contract; or

24 (C) Plan provided by a multiple employer welfare arrangement or by an-  
25 other benefit arrangement defined in the federal Employee Retirement In-  
26 come Security Act of 1974, as amended, to the extent that the plan is subject  
27 to state regulation.

28 (b) "Health benefit plan" does not include:

29 (A) Coverage for accident only, specific disease or condition only, credit  
30 or disability income;

31 (B) Coverage of Medicare services pursuant to contracts with the federal



1 government;

2 (C) Medicare supplement insurance policies;

3 (D) Coverage of TRICARE services pursuant to contracts with the federal  
4 government;

5 (E) Benefits delivered through a flexible spending arrangement estab-  
6 lished pursuant to section 125 of the Internal Revenue Code of 1986, as  
7 amended, when the benefits are provided in addition to a group health ben-  
8 efit plan;

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

12 (G) Independent, noncoordinated, hospital-only indemnity insurance or  
13 other fixed indemnity insurance;

14 (H) Short term health insurance policies that are in effect for periods of  
15 12 months or less, including the term of a renewal of the policy;

16 (I) Dental only coverage;

17 (J) Vision only coverage;

18 (K) Stop-loss coverage that meets the requirements of ORS 742.065;

19 (L) Coverage issued as a supplement to liability insurance;

20 (M) Insurance arising out of a workers' compensation or similar law;

21 (N) Automobile medical payment insurance or insurance under which  
22 benefits are payable with or without regard to fault and that is statutorily  
23 required to be contained in any liability insurance policy or equivalent self-  
24 insurance; or

25 (O) Any employee welfare benefit plan that is exempt from state regu-  
26 lation because of the federal Employee Retirement Income Security Act of  
27 1974, as amended.

28 (c) For purposes of this subsection, renewal of a short term health in-  
29 surance policy includes the issuance of a new short term health insurance  
30 policy by an insurer to a policyholder within 60 days after the expiration of  
31 a policy previously issued by the insurer to the policyholder.

1 (21) "Health statement" means any information that is intended to inform  
2 the carrier or insurance producer of the health status of an enrollee or pro-  
3 spective enrollee in a health benefit plan. "Health statement" includes the  
4 standard health statement approved by the director under ORS 743.745.

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

8 (23) "Initial enrollment period" means a period of at least 30 days fol-  
9 lowing commencement of the first eligibility period for an individual.

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

14 (a) The individual qualifies for a special enrollment period in accordance  
15 with 42 U.S.C. 300gg as amended and in effect on February 17, 2009;

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

17 (c) A court issues an order that coverage be provided for a spouse or  
18 minor child under an employee's employer sponsored health benefit plan and  
19 request for enrollment is made within 30 days after issuance of the court  
20 order;

21 (d) The individual is employed by an employer that offers multiple health  
22 benefit plans and the individual elects a different health benefit plan during  
23 an open enrollment period; or

24 (e) The individual's coverage under Medicaid, Medicare, TRICARE, In-  
25 dian Health Service or a publicly sponsored or subsidized health plan, in-  
26 cluding, but not limited to, the medical assistance program under ORS  
27 chapter 414, has been involuntarily terminated within 63 days after applying  
28 for coverage in a group health benefit plan.

29 (25) "Minimal essential coverage" has the meaning given that term in  
30 section 5000A(f) of the Internal Revenue Code.

31 (26) "Multiple employer welfare arrangement" means a multiple employer

1 welfare arrangement as defined in section 3 of the federal Employee Retirement  
2 Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject  
3 to ORS 750.301 to 750.341.

4 [(27) *“Oregon Medical Insurance Pool” means the pool created under ORS*  
5 *735.610.*]

6 [(28)] **(27)** “Preexisting condition exclusion” means a health benefit plan  
7 provision applicable to an enrollee or late enrollee that excludes coverage  
8 for services, charges or expenses incurred during a specified period imme-  
9 diately following enrollment for a condition for which medical advice, diag-  
10 nosis, care or treatment was recommended or received during a specified  
11 period immediately preceding enrollment. For purposes of ORS 743.730 to  
12 743.773:

13 (a) Pregnancy does not constitute a preexisting condition except as pro-  
14 vided in ORS 743.766;

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

17 (c) Except for coverage under an individual grandfathered health plan, a  
18 preexisting condition exclusion may not exclude coverage for services,  
19 charges or expenses incurred by an individual who is under 19 years of age.

20 [(29)] **(28)** “Premium” includes insurance premiums or other fees charged  
21 for a health benefit plan, including the costs of benefits paid or reimburse-  
22 ments made to or on behalf of enrollees covered by the plan.

23 [(30)] **(29)** “Rating period” means the 12-month calendar period for which  
24 premium rates established by a carrier are in effect, as determined by the  
25 carrier.

26 [(31)] **(30)** “Representative” does not include an insurance producer or an  
27 employee or authorized representative of an insurance producer or carrier.

28 [(32)] **(31)** “Silver plan” means an individual or small group health benefit  
29 plan that meets the criteria for a silver plan prescribed by the director by  
30 rule pursuant to ORS 743.822 (2).

31 [(33)(a)] **(32)(a)** “Small employer” means an employer that employed an

1 average of at least two but not more than 50 employees on business days  
2 during the preceding calendar year, the majority of whom are employed  
3 within this state, and that employs at least two eligible employees on the  
4 date on which coverage takes effect under a health benefit plan offered by  
5 the employer.

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

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

13 **SECTION 21.** ORS 743.748, as amended by section 18, chapter 500, Oregon  
14 Laws 2011, is amended to read:

15 743.748. (1) Each carrier offering a health benefit plan shall submit to the  
16 Director of the Department of Consumer and Business Services on or before  
17 April 1 of each year a report that contains:

18 (a) The following information for the preceding year that is derived from  
19 the exhibit of premiums, enrollment and utilization included in the carrier's  
20 annual report:

21 (A) The total number of members;

22 (B) The total amount of premiums;

23 (C) The total amount of costs for claims;

24 (D) The medical loss ratio;

25 (E) The average amount of premiums per member per month; and

26 (F) The percentage change in the average premium per member per month,  
27 measured from the previous year.

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

30 (A) The total amount of general administrative expenses, including iden-  
31 tification of the five largest nonmedical administrative expenses [*and the*

1 *assessment against the carrier for the Oregon Medical Insurance Pool*];

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

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

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

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

6 (2) A carrier shall electronically submit the information described in  
7 subsection (1) of this section in a format and according to instructions pre-  
8 scribed by the Department of Consumer and Business Services by rule.

9 (3) The department shall evaluate the reporting requirements under sub-  
10 section (1)(a) of this section by the following market segments:

11 (a) Individual health benefit plans;

12 (b) Health benefit plans for small employers;

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

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

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

17 **SECTION 22.** ORS 743.766, as amended by section 4, chapter 24, Oregon  
18 Laws 2012, is amended to read:

19 743.766. (1) All carriers that offer an individual health benefit plan and  
20 evaluate the health status of individuals for purposes of eligibility shall use  
21 the standard health statement established under ORS 743.745 and may not  
22 use any other method to determine the health status of an individual.  
23 Nothing in this subsection shall prevent a carrier from using health infor-  
24 mation after enrollment for the purpose of providing services or arranging  
25 for the provision of services under a health benefit plan.

26 (2)(a) If an individual is accepted for coverage under an individual health  
27 benefit plan, the carrier shall not impose exclusions or limitations other  
28 than:

29 (A) A preexisting condition exclusion that complies with the following  
30 requirements:

31 (i) The exclusion applies only to a condition for which medical advice,

1 diagnosis, care or treatment was recommended or received during the six-  
2 month period immediately preceding the individual's effective date of cover-  
3 age;

4 (ii) The exclusion expires no later than six months after the individual's  
5 effective date of coverage; and

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

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

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

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

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

23 [(4) *If an eligible prospective enrollee is rejected for coverage under an in-*  
24 *dividual health benefit plan, the prospective enrollee shall be eligible to apply*  
25 *for coverage under the Oregon Medical Insurance Pool.*]

26 [(5)] (4) If a carrier accepts an individual for coverage under an individual  
27 health benefit plan, the carrier shall renew the policy unless:

28 (a) The policyholder fails to pay the required premiums.

29 (b) The policyholder or a representative of the policyholder engages in  
30 fraud or makes an intentional misrepresentation of a material fact as pro-  
31 hibited by the terms of the policy.

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

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

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

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

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

19 (d) The carrier discontinues offering and renewing an individual health  
20 benefit plan in a specified service area within this state because of an ina-  
21 bility to reach an agreement with the health care providers or organization  
22 of health care providers to provide services under the plan within the service  
23 area. In order to discontinue a plan under this paragraph, the carrier:

24 (A) Must give notice of the decision to the department and to all  
25 policyholders covered by the plan;

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

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

1 (e) The carrier discontinues offering or renewing, or offering and renew-  
2 ing, an individual health benefit plan, other than a grandfathered health  
3 plan, for all individuals in this state or in a specified service area within this  
4 state, other than a plan discontinued under paragraph (d) of this subsection.

5 (f) The carrier discontinues renewing or offering and renewing a grand-  
6 fathered health plan for all individuals in this state or in a specified service  
7 area within this state, other than a plan discontinued under paragraph (d)  
8 of this subsection.

9 (g) With respect to plans that are being discontinued under paragraph (e)  
10 or (f) of this subsection, the carrier must:

11 (A) Offer in writing to each policyholder covered by the plan, all health  
12 benefit plans that the carrier offers to individuals in the specified service  
13 area.

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

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

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

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

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

23 (i) In the case of an individual health benefit plan that delivers covered  
24 services through a specified network of health care providers, the enrollee  
25 no longer lives, resides or works in the service area of the provider network  
26 and the termination of coverage is not related to the health status of any  
27 enrollee.

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



1        [(6)] (5) A carrier may modify an individual health benefit plan at the  
2 time of coverage renewal. The modification is not a discontinuation of the  
3 plan under subsection [(5)(c)] (4)(c), (e) and (f) of this section.

4        [(7)] (6) Notwithstanding any other provision of this section, and subject  
5 to the provisions of ORS 743.894 (2) and (4), a carrier may rescind an indi-  
6 vidual health benefit plan if the policyholder or a representative of the  
7 policyholder:

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

9        (b) Makes an intentional misrepresentation of a material fact as prohib-  
10 ited by the terms of the policy.

11       [(8)] (7) A carrier that withdraws from the market for individual health  
12 benefit plans must continue to renew its portability health benefit plans that  
13 have been approved pursuant to ORS 743.761.

14       [(9)] (8) A carrier that continues to offer coverage in the individual mar-  
15 ket in this state is not required to offer coverage in all of the carrier's in-  
16 dividual health benefit plans. However, if a carrier elects to continue a plan  
17 that is closed to new individual policyholders instead of offering alternative  
18 coverage in its other individual health benefit plans, the coverage for all  
19 existing policyholders in the closed plan is renewable in accordance with  
20 subsection [(5)] (4) of this section.

21       [(10)] (9) An individual health benefit plan may not impose annual or  
22 lifetime limits on the dollar amount of the essential health benefits pre-  
23 scribed by the United States Secretary of Health and Human Services pur-  
24 suant to 42 U.S.C. 300gg-11, except as permitted by federal law.

25       [(11)] (10) This section does not require a carrier to actively market, offer,  
26 issue or accept applications for a grandfathered health plan or from an in-  
27 dividual not eligible for coverage under such a plan as provided by the Pa-  
28 tient Protection and Affordable Care Act (P.L. 111-148) as amended by the  
29 Health Care and Education Reconciliation Act (P.L. 111-152).

30       **SECTION 23.** ORS 743.767 is amended to read:

31       743.767. Premium rates for individual health benefit plans shall be subject

1 to the following provisions:

2 (1) Each carrier must file the carrier's initial geographic average rate and  
3 any changes to the geographic average rate for its individual health benefit  
4 plans with the Director of the Department of Consumer and Business Ser-  
5 vices.

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

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

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

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

24 *[(4) Notwithstanding any other provision of this section, a carrier that im-*  
25 *poses an individual coverage waiting period pursuant to ORS 743.766 may*  
26 *impose a monthly premium rate surcharge for a period not to exceed six*  
27 *months and in an amount not to exceed the percentage by which the rates for*  
28 *coverage under the Oregon Medical Insurance Pool exceed the rates established*  
29 *by the Oregon Medical Insurance Pool Board as applicable for individual*  
30 *risks under ORS 735.625. The surcharge shall be approved by the Director of*  
31 *the Department of Consumer and Business Services and, in combination with*

1 *the waiting period, shall not exceed the actuarial value of a six-month preex-*  
2 *isting condition exclusion.]*

3 **SECTION 24.** ORS 746.600 is amended to read:

4 746.600. As used in ORS 746.600 to 746.690:

5 (1)(a) “Adverse underwriting decision” means any of the following actions  
6 with respect to insurance transactions involving insurance coverage that is  
7 individually underwritten:

8 (A) A declination of insurance coverage.

9 (B) A termination of insurance coverage.

10 (C) Failure of an insurance producer to apply for insurance coverage with  
11 a specific insurer that the insurance producer represents and that is re-  
12 quested by an applicant.

13 (D) In the case of life or health insurance coverage, an offer to insure at  
14 higher than standard rates.

15 (E) In the case of insurance coverage other than life or health insurance  
16 coverage:

17 (i) Placement by an insurer or insurance producer of a risk with a resi-  
18 dual market mechanism, an unauthorized insurer or an insurer that special-  
19 izes in substandard risks.

20 (ii) The charging of a higher rate on the basis of information that differs  
21 from that which the applicant or policyholder furnished.

22 (iii) An increase in any charge imposed by the insurer for any personal  
23 insurance in connection with the underwriting of insurance. For purposes  
24 of this sub-subparagraph, the imposition of a service fee is not a charge.

25 (b) “Adverse underwriting decision” does not mean any of the following  
26 actions, but the insurer or insurance producer responsible for the occurrence  
27 of the action must nevertheless provide the applicant or policyholder with  
28 the specific reason or reasons for the occurrence:

29 (A) The termination of an individual policy form on a class or statewide  
30 basis.

31 (B) A declination of insurance coverage solely because the coverage is

1 not available on a class or statewide basis.

2 (C) The rescission of a policy.

3 (2) "Affiliate of" a specified person or "person affiliated with" a specified  
4 person means a person who directly, or indirectly, through one or more in-  
5 termediaries, controls, or is controlled by, or is under common control with,  
6 the person specified.

7 (3) "Applicant" means a person who seeks to contract for insurance cov-  
8 erage, other than a person seeking group insurance coverage that is not in-  
9 dividually underwritten.

10 (4) "Consumer" means an individual, or the personal representative of the  
11 individual, who seeks to obtain, obtains or has obtained one or more insur-  
12 ance products or services from a licensee that are to be used primarily for  
13 personal, family or household purposes, and about whom the licensee has  
14 personal information.

15 (5) "Consumer report" means any written, oral or other communication  
16 of information bearing on a natural person's creditworthiness, credit stand-  
17 ing, credit capacity, character, general reputation, personal characteristics  
18 or mode of living that is used or expected to be used in connection with an  
19 insurance transaction.

20 (6) "Consumer reporting agency" means a person that, for monetary fees  
21 or dues, or on a cooperative or nonprofit basis:

22 (a) Regularly engages, in whole or in part, in assembling or preparing  
23 consumer reports;

24 (b) Obtains information primarily from sources other than insurers; and

25 (c) Furnishes consumer reports to other persons.

26 (7) "Control" means, and the terms "controlled by" or "under common  
27 control with" refer to, the possession, directly or indirectly, of the power to  
28 direct or cause the direction of the management and policies of a person,  
29 whether through the ownership of voting securities, by contract other than  
30 a commercial contract for goods or nonmanagement services, or otherwise,  
31 unless the power of the person is the result of a corporate office held in, or

1 an official position held with, the controlled person.

2 (8) "Covered entity" means:

3 (a) A health insurer;

4 (b) A health care provider that transmits any health information in elec-  
5 tronic form to carry out financial or administrative activities in connection  
6 with a transaction covered by ORS 746.607 or by rules adopted under ORS  
7 746.608; or

8 (c) A health care clearinghouse.

9 (9) "Credit history" means any written or other communication of any  
10 information by a consumer reporting agency that:

11 (a) Bears on a consumer's creditworthiness, credit standing or credit ca-  
12 pacity; and

13 (b) Is used or expected to be used, or collected in whole or in part, as a  
14 factor in determining eligibility, premiums or rates for personal insurance.

15 (10) "Customer" means a consumer who has a continuing relationship  
16 with a licensee under which the licensee provides one or more insurance  
17 products or services to the consumer that are to be used primarily for per-  
18 sonal, family or household purposes.

19 (11) "Declination of insurance coverage" or "decline coverage" means a  
20 denial, in whole or in part, by an insurer or insurance producer of an ap-  
21 plication for requested insurance coverage.

22 (12) "Health care" means care, services or supplies related to the health  
23 of an individual.

24 (13) "Health care operations" includes but is not limited to:

25 (a) Quality assessment, accreditation, auditing and improvement activ-  
26 ities;

27 (b) Case management and care coordination;

28 (c) Reviewing the competence, qualifications or performance of health  
29 care providers or health insurers;

30 (d) Underwriting activities;

31 (e) Arranging for legal services;

- 1 (f) Business planning;
- 2 (g) Customer services;
- 3 (h) Resolving internal grievances;
- 4 (i) Creating deidentified information; and
- 5 (j) Fundraising.

6 (14) "Health care provider" includes but is not limited to:

7 (a) A psychologist, occupational therapist, regulated social worker, pro-  
8 fessional counselor or marriage and family therapist licensed or otherwise  
9 authorized to practice under ORS chapter 675 or an employee of the psy-  
10 chologist, occupational therapist, regulated social worker, professional  
11 counselor or marriage and family therapist;

12 (b) A physician, podiatric physician and surgeon, physician assistant or  
13 acupuncturist licensed under ORS chapter 677 or an employee of the physi-  
14 cian, podiatric physician and surgeon, physician assistant or acupuncturist;

15 (c) A nurse or nursing home administrator licensed under ORS chapter  
16 678 or an employee of the nurse or nursing home administrator;

17 (d) A dentist licensed under ORS chapter 679 or an employee of the den-  
18 tist;

19 (e) A dental hygienist or denturist licensed under ORS chapter 680 or an  
20 employee of the dental hygienist or denturist;

21 (f) A speech-language pathologist or audiologist licensed under ORS  
22 chapter 681 or an employee of the speech-language pathologist or audiologist;

23 (g) An emergency medical services provider licensed under ORS chapter  
24 682;

25 (h) An optometrist licensed under ORS chapter 683 or an employee of the  
26 optometrist;

27 (i) A chiropractic physician licensed under ORS chapter 684 or an em-  
28 ployee of the chiropractic physician;

29 (j) A naturopathic physician licensed under ORS chapter 685 or an em-  
30 ployee of the naturopathic physician;

31 (k) A massage therapist licensed under ORS 687.011 to 687.250 or an em-

1 ployee of the massage therapist;

2 (L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an  
3 employee of the direct entry midwife;

4 (m) A physical therapist licensed under ORS 688.010 to 688.201 or an em-  
5 ployee of the physical therapist;

6 (n) A medical imaging licensee under ORS 688.405 to 688.605 or an em-  
7 ployee of the medical imaging licensee;

8 (o) A respiratory care practitioner licensed under ORS 688.815 or an em-  
9 ployee of the respiratory care practitioner;

10 (p) A polysomnographic technologist licensed under ORS 688.819 or an  
11 employee of the polysomnographic technologist;

12 (q) A pharmacist licensed under ORS chapter 689 or an employee of the  
13 pharmacist;

14 (r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of  
15 the dietitian;

16 (s) A funeral service practitioner licensed under ORS chapter 692 or an  
17 employee of the funeral service practitioner;

18 (t) A health care facility as defined in ORS 442.015;

19 (u) A home health agency as defined in ORS 443.005;

20 (v) A hospice program as defined in ORS 443.850;

21 (w) A clinical laboratory as defined in ORS 438.010;

22 (x) A pharmacy as defined in ORS 689.005;

23 (y) A diabetes self-management program as defined in ORS 743.694; and

24 (z) Any other person or entity that furnishes, bills for or is paid for health  
25 care in the normal course of business.

26 (15) "Health information" means any oral or written information in any  
27 form or medium that:

28 (a) Is created or received by a covered entity, a public health authority,  
29 a life insurer, a school, a university or a health care provider that is not a  
30 covered entity; and

31 (b) Relates to:

1 (A) The past, present or future physical or mental health or condition of  
2 an individual;

3 (B) The provision of health care to an individual; or

4 (C) The past, present or future payment for the provision of health care  
5 to an individual.

6 (16) “Health insurer” means[:]

7 [(a)] an insurer who offers:

8 [(A)] (a) A health benefit plan as defined in ORS 743.730;

9 [(B)] (b) A short term health insurance policy, the duration of which does  
10 not exceed six months including renewals;

11 [(C)] (c) A student health insurance policy;

12 [(D)] (d) A Medicare supplemental policy; or

13 [(E)] (e) A dental only policy.

14 [(b) *The Oregon Medical Insurance Pool operated by the Oregon Medical*  
15 *Insurance Pool Board under ORS 735.600 to 735.650.*]

16 (17) “Homeowner insurance” means insurance for residential property  
17 consisting of a combination of property insurance and casualty insurance  
18 that provides coverage for the risks of owning or occupying a dwelling and  
19 that is not intended to cover an owner’s interest in rental property or com-  
20 mercial exposures.

21 (18) “Individual” means a natural person who:

22 (a) In the case of life or health insurance, is a past, present or proposed  
23 principal insured or certificate holder;

24 (b) In the case of other kinds of insurance, is a past, present or proposed  
25 named insured or certificate holder;

26 (c) Is a past, present or proposed policyowner;

27 (d) Is a past or present applicant;

28 (e) Is a past or present claimant; or

29 (f) Derived, derives or is proposed to derive insurance coverage under an  
30 insurance policy or certificate that is subject to ORS 746.600 to 746.690.

31 (19) “Individually identifiable health information” means any oral or



1 written health information that is:

2 (a) Created or received by a covered entity or a health care provider that  
3 is not a covered entity; and

4 (b) Identifiable to an individual, including demographic information that  
5 identifies the individual, or for which there is a reasonable basis to believe  
6 the information can be used to identify an individual, and that relates to:

7 (A) The past, present or future physical or mental health or condition of  
8 an individual;

9 (B) The provision of health care to an individual; or

10 (C) The past, present or future payment for the provision of health care  
11 to an individual.

12 (20) "Institutional source" means a person or governmental entity that  
13 provides information about an individual to an insurer, insurance producer  
14 or insurance-support organization, other than:

15 (a) An insurance producer;

16 (b) The individual who is the subject of the information; or

17 (c) A natural person acting in a personal capacity rather than in a busi-  
18 ness or professional capacity.

19 (21) "Insurance producer" or "producer" means a person licensed by the  
20 Director of the Department of Consumer and Business Services as a resident  
21 or nonresident insurance producer.

22 (22) "Insurance score" means a number or rating that is derived from an  
23 algorithm, computer application, model or other process that is based in  
24 whole or in part on credit history.

25 (23)(a) "Insurance-support organization" means a person who regularly  
26 engages, in whole or in part, in assembling or collecting information about  
27 natural persons for the primary purpose of providing the information to an  
28 insurer or insurance producer for insurance transactions, including:

29 (A) The furnishing of consumer reports to an insurer or insurance pro-  
30 ducer for use in connection with insurance transactions; and

31 (B) The collection of personal information from insurers, insurance pro-

1 ducers or other insurance-support organizations for the purpose of detecting  
2 or preventing fraud, material misrepresentation or material nondisclosure in  
3 connection with insurance underwriting or insurance claim activity.

4 (b) "Insurance-support organization" does not mean insurers, insurance  
5 producers, governmental institutions or health care providers.

6 (24) "Insurance transaction" means any transaction that involves insur-  
7 ance primarily for personal, family or household needs rather than business  
8 or professional needs and that entails:

9 (a) The determination of an individual's eligibility for an insurance cov-  
10 erage, benefit or payment; or

11 (b) The servicing of an insurance application, policy or certificate.

12 (25) "Insurer" has the meaning given that term in ORS 731.106.

13 (26) "Investigative consumer report" means a consumer report, or portion  
14 of a consumer report, for which information about a natural person's char-  
15 acter, general reputation, personal characteristics or mode of living is ob-  
16 tained through personal interviews with the person's neighbors, friends,  
17 associates, acquaintances or others who may have knowledge concerning  
18 such items of information.

19 (27) "Licensee" means an insurer, insurance producer or other person  
20 authorized or required to be authorized, or licensed or required to be li-  
21 censed, pursuant to the Insurance Code.

22 (28) "Loss history report" means a report provided by, or a database  
23 maintained by, an insurance-support organization or consumer reporting  
24 agency that contains information regarding the claims history of the indi-  
25 vidual property that is the subject of the application for a homeowner in-  
26 surance policy or the consumer applying for a homeowner insurance policy.

27 (29) "Nonaffiliated third party" means any person except:

28 (a) An affiliate of a licensee;

29 (b) A person that is employed jointly by a licensee and by a person that  
30 is not an affiliate of the licensee; and

31 (c) As designated by the director by rule.

1 (30) "Payment" includes but is not limited to:

2 (a) Efforts to obtain premiums or reimbursement;

3 (b) Determining eligibility or coverage;

4 (c) Billing activities;

5 (d) Claims management;

6 (e) Reviewing health care to determine medical necessity;

7 (f) Utilization review; and

8 (g) Disclosures to consumer reporting agencies.

9 (31)(a) "Personal financial information" means:

10 (A) Information that is identifiable with an individual, gathered in con-  
11 nection with an insurance transaction from which judgments can be made  
12 about the individual's character, habits, avocations, finances, occupations,  
13 general reputation, credit or any other personal characteristics; or

14 (B) An individual's name, address and policy number or similar form of  
15 access code for the individual's policy.

16 (b) "Personal financial information" does not mean information that a  
17 licensee has a reasonable basis to believe is lawfully made available to the  
18 general public from federal, state or local government records, widely dis-  
19 tributed media or disclosures to the public that are required by federal, state  
20 or local law.

21 (32) "Personal information" means:

22 (a) Personal financial information;

23 (b) Individually identifiable health information; or

24 (c) Protected health information.

25 (33) "Personal insurance" means the following types of insurance products  
26 or services that are to be used primarily for personal, family or household  
27 purposes:

28 (a) Private passenger automobile coverage;

29 (b) Homeowner, mobile homeowners, manufactured homeowners, condo-  
30 minium owners and renters coverage;

31 (c) Personal dwelling property coverage;

1 (d) Personal liability and theft coverage, including excess personal li-  
2 ability and theft coverage; and

3 (e) Personal inland marine coverage.

4 (34) "Personal representative" includes but is not limited to:

5 (a) A person appointed as a guardian under ORS 125.305, 419B.370,  
6 419C.481 or 419C.555 with authority to make medical and health care deci-  
7 sions;

8 (b) A person appointed as a health care representative under ORS 127.505  
9 to 127.660 or 127.700 to 127.737 to make health care decisions or mental  
10 health treatment decisions;

11 (c) A person appointed as a personal representative under ORS chapter  
12 113; and

13 (d) A person described in ORS 746.611.

14 (35) "Policyholder" means a person who:

15 (a) In the case of individual policies of life or health insurance, is a cur-  
16 rent policyowner;

17 (b) In the case of individual policies of other kinds of insurance, is cur-  
18 rently a named insured; or

19 (c) In the case of group policies of insurance under which coverage is  
20 individually underwritten, is a current certificate holder.

21 (36) "Pretext interview" means an interview wherein the interviewer, in  
22 an attempt to obtain personal information about a natural person, does one  
23 or more of the following:

24 (a) Pretends to be someone the interviewer is not.

25 (b) Pretends to represent a person the interviewer is not in fact repre-  
26 senting.

27 (c) Misrepresents the true purpose of the interview.

28 (d) Refuses upon request to identify the interviewer.

29 (37) "Privileged information" means information that is identifiable with  
30 an individual and that:

31 (a) Relates to a claim for insurance benefits or a civil or criminal pro-

1 ceeding involving the individual; and

2 (b) Is collected in connection with or in reasonable anticipation of a claim  
3 for insurance benefits or a civil or criminal proceeding involving the indi-  
4 vidual.

5 (38)(a) "Protected health information" means individually identifiable  
6 health information that is transmitted or maintained in any form of elec-  
7 tronic or other medium by a covered entity.

8 (b) "Protected health information" does not mean individually identifiable  
9 health information in:

10 (A) Education records covered by the federal Family Educational Rights  
11 and Privacy Act (20 U.S.C. 1232g);

12 (B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

13 (C) Employment records held by a covered entity in its role as employer.

14 (39) "Residual market mechanism" means an association, organization or  
15 other entity involved in the insuring of risks under ORS 735.005 to 735.145,  
16 737.312 or other provisions of the Insurance Code relating to insurance ap-  
17 plicants who are unable to procure insurance through normal insurance  
18 markets.

19 (40) "Termination of insurance coverage" or "termination of an insurance  
20 policy" means either a cancellation or a nonrenewal of an insurance policy,  
21 in whole or in part, for any reason other than the failure of a premium to  
22 be paid as required by the policy.

23 (41) "Treatment" includes but is not limited to:

24 (a) The provision, coordination or management of health care; and

25 (b) Consultations and referrals between health care providers.

26

27

**TERMINATION OF TEMPORARY HIGH  
RISK POOL PROGRAM**

28

29

30 **SECTION 25.** Section 5, chapter 47, Oregon Laws 2010, is amended to  
31 read:

1       **Sec. 5.** Sections 1 to 3 [*of this 2010 Act*], chapter 47, Oregon Laws 2010,  
2 are repealed on [*January 2, 2016*] **January 1, 2014.**

3  
4                                   **ABOLISHMENT OF OREGON**  
5                                   **MEDICAL INSURANCE POOL BOARD**

6  
7       **SECTION 26.** The Oregon Medical Insurance Pool and the Oregon  
8 Medical Insurance Pool Account are abolished. On the operative date  
9 of this section, the tenure of office of the members of the Oregon  
10 Medical Insurance Pool Board ceases.

11       **SECTION 27.** Before the operative date of section 26 of this 2013 Act,  
12 the Oregon Medical Insurance Pool Board shall pay all valid out-  
13 standing claims against the Oregon Medical Insurance Pool. Any bal-  
14 ances of amounts remaining in the Oregon Medical Insurance Pool  
15 Account after the payment of claims shall be refunded to insurers in  
16 a manner determined by the board to be fair and equitable.

17       **SECTION 28.** (1) Nothing in section 26 or 27 of this 2013 Act, the  
18 amendments to statutes and session law by sections 9 to 25, 29 to 33,  
19 35 and 36 of this 2013 Act or the repeal of statutes and session law by  
20 section 39 of this 2013 Act relieves a person of a liability, duty or ob-  
21 ligation accruing under or with respect to the duties, functions and  
22 powers of the Oregon Medical Insurance Pool Board. The Oregon  
23 Health Authority may undertake the collection or enforcement of any  
24 such liability, duty or obligation.

25       (2) The rights and obligations of the board legally incurred under  
26 contracts, leases and business transactions executed, entered into or  
27 begun before the operative date of section 26 of this 2013 Act are  
28 transferred to the authority. For the purpose of succession to these  
29 rights and obligations, the authority is a continuation of the board and  
30 not a new authority.

31       (3) Notwithstanding the abolishment of the Oregon Medical Insur-

1 **ance Pool by section 26 of this 2013 Act, the rules of the board in effect**  
2 **on the effective date of this 2013 Act continue in effect until super-**  
3 **seded or repealed by rules of the authority. References in rules of the**  
4 **board to the board or an officer or employee of the board are consid-**  
5 **ered to be references to the authority or an officer or employee of the**  
6 **authority.**

7 (4) **Whenever, in any statutory law or resolution of the Legislative**  
8 **Assembly or in any rule, document, record or proceeding authorized**  
9 **by the Legislative Assembly, reference is made to the board or an of-**  
10 **ficer or employee of the board, the reference is considered to be a**  
11 **reference to the authority or an officer or employee of the authority.**

12 **SECTION 29.** ORS 65.957 is amended to read:

13 65.957. (1) This chapter applies to all domestic corporations in existence  
14 on October 3, 1989, that were incorporated under any general statute of this  
15 state providing for incorporation of nonprofit corporations if power to amend  
16 or repeal the statute under which the corporation was incorporated was re-  
17 served.

18 (2) Without limitation as to any other corporations that may be outside  
19 the scope of subsection (1) of this section, this chapter does not apply to the  
20 following:

21 (a) The Oregon State Bar and the Oregon State Bar Professional Liability  
22 Fund created under ORS 9.005 to 9.755;

23 (b) The State Accident Insurance Fund Corporation created under ORS  
24 chapter 656;

25 (c) The Oregon Insurance Guaranty Association and the Oregon Life and  
26 Health Insurance Guaranty Association created under ORS chapter 734; and

27 (d) The Oregon FAIR Plan Association [*and the Oregon Medical Insurance*  
28 *Pool*] created under ORS [*chapter 735*] **735.045.**

29 **SECTION 30.** ORS 192.556 is amended to read:

30 192.556. As used in ORS 192.553 to 192.581:

31 (1) "Authorization" means a document written in plain language that

1 contains at least the following:

2 (a) A description of the information to be used or disclosed that identifies  
3 the information in a specific and meaningful way;

4 (b) The name or other specific identification of the person or persons  
5 authorized to make the requested use or disclosure;

6 (c) The name or other specific identification of the person or persons to  
7 whom the covered entity may make the requested use or disclosure;

8 (d) A description of each purpose of the requested use or disclosure, in-  
9 cluding but not limited to a statement that the use or disclosure is at the  
10 request of the individual;

11 (e) An expiration date or an expiration event that relates to the individ-  
12 ual or the purpose of the use or disclosure;

13 (f) The signature of the individual or personal representative of the indi-  
14 vidual and the date;

15 (g) A description of the authority of the personal representative, if ap-  
16 plicable; and

17 (h) Statements adequate to place the individual on notice of the following:

18 (A) The individual's right to revoke the authorization in writing;

19 (B) The exceptions to the right to revoke the authorization;

20 (C) The ability or inability to condition treatment, payment, enrollment  
21 or eligibility for benefits on whether the individual signs the authorization;  
22 and

23 (D) The potential for information disclosed pursuant to the authorization  
24 to be subject to redisclosure by the recipient and no longer protected.

25 (2) "Covered entity" means:

26 (a) A state health plan;

27 (b) A health insurer;

28 (c) A health care provider that transmits any health information in elec-  
29 tronic form to carry out financial or administrative activities in connection  
30 with a transaction covered by ORS 192.553 to 192.581; or

31 (d) A health care clearinghouse.



1 (3) "Health care" means care, services or supplies related to the health  
2 of an individual.

3 (4) "Health care operations" includes but is not limited to:

4 (a) Quality assessment, accreditation, auditing and improvement activ-  
5 ities;

6 (b) Case management and care coordination;

7 (c) Reviewing the competence, qualifications or performance of health  
8 care providers or health insurers;

9 (d) Underwriting activities;

10 (e) Arranging for legal services;

11 (f) Business planning;

12 (g) Customer services;

13 (h) Resolving internal grievances;

14 (i) Creating deidentified information; and

15 (j) Fundraising.

16 (5) "Health care provider" includes but is not limited to:

17 (a) A psychologist, occupational therapist, regulated social worker, pro-  
18 fessional counselor or marriage and family therapist licensed or otherwise  
19 authorized to practice under ORS chapter 675 or an employee of the psy-  
20 chologist, occupational therapist, regulated social worker, professional  
21 counselor or marriage and family therapist;

22 (b) A physician, podiatric physician and surgeon, physician assistant or  
23 acupuncturist licensed under ORS chapter 677 or an employee of the physi-  
24 cian, podiatric physician and surgeon, physician assistant or acupuncturist;

25 (c) A nurse or nursing home administrator licensed under ORS chapter  
26 678 or an employee of the nurse or nursing home administrator;

27 (d) A dentist licensed under ORS chapter 679 or an employee of the den-  
28 tist;

29 (e) A dental hygienist or denturist licensed under ORS chapter 680 or an  
30 employee of the dental hygienist or denturist;

31 (f) A speech-language pathologist or audiologist licensed under ORS

- 1 chapter 681 or an employee of the speech-language pathologist or audiologist;
- 2 (g) An emergency medical services provider licensed under ORS chapter  
3 682;
- 4 (h) An optometrist licensed under ORS chapter 683 or an employee of the  
5 optometrist;
- 6 (i) A chiropractic physician licensed under ORS chapter 684 or an em-  
7 ployee of the chiropractic physician;
- 8 (j) A naturopathic physician licensed under ORS chapter 685 or an em-  
9 ployee of the naturopathic physician;
- 10 (k) A massage therapist licensed under ORS 687.011 to 687.250 or an em-  
11 ployee of the massage therapist;
- 12 (L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an  
13 employee of the direct entry midwife;
- 14 (m) A physical therapist licensed under ORS 688.010 to 688.201 or an em-  
15 ployee of the physical therapist;
- 16 (n) A medical imaging licensee under ORS 688.405 to 688.605 or an em-  
17 ployee of the medical imaging licensee;
- 18 (o) A respiratory care practitioner licensed under ORS 688.815 or an em-  
19 ployee of the respiratory care practitioner;
- 20 (p) A polysomnographic technologist licensed under ORS 688.819 or an  
21 employee of the polysomnographic technologist;
- 22 (q) A pharmacist licensed under ORS chapter 689 or an employee of the  
23 pharmacist;
- 24 (r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of  
25 the dietitian;
- 26 (s) A funeral service practitioner licensed under ORS chapter 692 or an  
27 employee of the funeral service practitioner;
- 28 (t) A health care facility as defined in ORS 442.015;
- 29 (u) A home health agency as defined in ORS 443.005;
- 30 (v) A hospice program as defined in ORS 443.850;
- 31 (w) A clinical laboratory as defined in ORS 438.010;

- 1 (x) A pharmacy as defined in ORS 689.005;  
2 (y) A diabetes self-management program as defined in ORS 743A.184; and  
3 (z) Any other person or entity that furnishes, bills for or is paid for health  
4 care in the normal course of business.

5 (6) "Health information" means any oral or written information in any  
6 form or medium that:

7 (a) Is created or received by a covered entity, a public health authority,  
8 an employer, a life insurer, a school, a university or a health care provider  
9 that is not a covered entity; and

10 (b) Relates to:

11 (A) The past, present or future physical or mental health or condition of  
12 an individual;

13 (B) The provision of health care to an individual; or

14 (C) The past, present or future payment for the provision of health care  
15 to an individual.

16 (7) "Health insurer" means[:]

17 [(a)] an insurer as defined in ORS 731.106 who offers:

18 [(A)] (a) A health benefit plan as defined in ORS 743.730;

19 [(B)] (b) A short term health insurance policy, the duration of which does  
20 not exceed six months including renewals;

21 [(C)] (c) A student health insurance policy;

22 [(D)] (d) A Medicare supplemental policy; or

23 [(E)] (e) A dental only policy.

24 [(b) *The Oregon Medical Insurance Pool operated by the Oregon Medical*  
25 *Insurance Pool Board under ORS 735.600 to 735.650.*]

26 (8) "Individually identifiable health information" means any oral or  
27 written health information in any form or medium that is:

28 (a) Created or received by a covered entity, an employer or a health care  
29 provider that is not a covered entity; and

30 (b) Identifiable to an individual, including demographic information that  
31 identifies the individual, or for which there is a reasonable basis to believe

1 the information can be used to identify an individual, and that relates to:

2 (A) The past, present or future physical or mental health or condition of  
3 an individual;

4 (B) The provision of health care to an individual; or

5 (C) The past, present or future payment for the provision of health care  
6 to an individual.

7 (9) "Payment" includes but is not limited to:

8 (a) Efforts to obtain premiums or reimbursement;

9 (b) Determining eligibility or coverage;

10 (c) Billing activities;

11 (d) Claims management;

12 (e) Reviewing health care to determine medical necessity;

13 (f) Utilization review; and

14 (g) Disclosures to consumer reporting agencies.

15 (10) "Personal representative" includes but is not limited to:

16 (a) A person appointed as a guardian under ORS 125.305, 419B.370,  
17 419C.481 or 419C.555 with authority to make medical and health care deci-  
18 sions;

19 (b) A person appointed as a health care representative under ORS 127.505  
20 to 127.660 or a representative under ORS 127.700 to 127.737 to make health  
21 care decisions or mental health treatment decisions;

22 (c) A person appointed as a personal representative under ORS chapter  
23 113; and

24 (d) A person described in ORS 192.573.

25 (11)(a) "Protected health information" means individually identifiable  
26 health information that is maintained or transmitted in any form of elec-  
27 tronic or other medium by a covered entity.

28 (b) "Protected health information" does not mean individually identifiable  
29 health information in:

30 (A) Education records covered by the federal Family Educational Rights  
31 and Privacy Act (20 U.S.C. 1232g);

1 (B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

2 (C) Employment records held by a covered entity in its role as employer.

3 (12) "State health plan" means:

4 (a) Medical assistance as defined in ORS 414.025;

5 (b) The Health Care for All Oregon Children program;

6 (c) The Family Health Insurance Assistance Program established in ORS  
7 414.841 to 414.864; or

8 (d) Any medical assistance or premium assistance program operated by  
9 the Oregon Health Authority.

10 (13) "Treatment" includes but is not limited to:

11 (a) The provision, coordination or management of health care; and

12 (b) Consultations and referrals between health care providers.

13 **SECTION 31.** ORS 744.704 is amended to read:

14 744.704. (1) The following persons are exempt from the licensing require-  
15 ment for third party administrators in ORS 744.702 and from all other pro-  
16 visions of ORS 744.700 to 744.740 applicable to third party administrators:

17 (a) A person licensed under ORS 744.002 as an adjuster, whose activities  
18 are limited to adjustment of claims and whose activities do not include the  
19 activities of a third party administrator.

20 (b) A person licensed as an insurance producer as required by ORS 744.053  
21 and authorized to transact life or health insurance in this state, whose ac-  
22 tivities are limited exclusively to the sale of insurance and whose activities  
23 do not include the activities of a third party administrator.

24 (c) An employer acting as a third party administrator on behalf of:

25 (A) Its employees;

26 (B) The employees of one or more subsidiary or affiliated corporations of  
27 the employer; or

28 (C) The employees of one or more persons with a dealership, franchise,  
29 distributorship or other similar arrangement with the employers.

30 (d) A union, or an affiliate thereof, acting as a third party administrator  
31 on behalf of its members.

1 (e) An insurer that is authorized to transact insurance in this state with  
2 respect to a policy issued and delivered in and pursuant to the laws of this  
3 state or another state.

4 (f) A creditor acting on behalf of its debtors with respect to insurance  
5 covering a debt between the creditor and its debtors.

6 (g) A trust and the trustees, agents and employees of the trust, when  
7 acting pursuant to the trust, if the trust is established in conformity with  
8 29 U.S.C. 186.

9 (h) A trust exempt from taxation under section 501(a) of the Internal  
10 Revenue Code, its trustees and employees acting pursuant to the trust, or a  
11 voluntary employees beneficiary association described in section 501(c) of the  
12 Internal Revenue Code, its agents and employees and a custodian and the  
13 custodian's agents and employees acting pursuant to a custodian account  
14 meeting the requirements of section 401(f) of the Internal Revenue Code.

15 (i) A financial institution that is subject to supervision or examination  
16 by federal or state financial institution regulatory authorities, or a mortgage  
17 lender, to the extent the financial institution or mortgage lender collects and  
18 remits premiums to licensed insurance producers or authorized insurers in  
19 connection with loan payments.

20 (j) A company that issues credit cards and advances for and collects pre-  
21 miums or charges from its credit card holders who have authorized col-  
22 lection. The exemption under this paragraph applies only if the company does  
23 not adjust or settle claims.

24 (k) A person who adjusts or settles claims in the normal course of prac-  
25 tice or employment as an attorney at law. The exemption under this sub-  
26 section applies only if the person does not collect charges or premiums in  
27 connection with life insurance or health insurance coverage.

28 (L) A person who acts solely as an administrator of one or more bona fide  
29 employee benefit plans established by an employer or an employee organiza-  
30 tion, or both, for which the Insurance Code is preempted pursuant to the  
31 Employee Retirement Income Security Act of 1974. A person to whom this

1 paragraph applies must comply with the requirements of ORS 744.714.

2 [(m) *The Oregon Medical Insurance Pool Board, established under ORS*  
3 *735.600 to 735.650, and the administering insurer or insurers for the board, for*  
4 *services provided pursuant to ORS 735.600 to 735.650.*]

5 [(n)] (m) An entity or association owned by or composed of like employers  
6 who administer partially or fully self-insured plans for employees of the em-  
7 ployers or association members.

8 [(o)] (n) A trust established by a cooperative body formed between cities,  
9 counties, districts or other political subdivisions of this state, or between  
10 any combination of such entities, and the trustees, agents and employees  
11 acting pursuant to the trust.

12 [(p)] (o) Any person designated by the Director of the Department of  
13 Consumer and Business Services by rule.

14 (2) A third party administrator is not required to be licensed as a third  
15 party administrator in this state if the following conditions are met:

16 (a) The third party administrator has its principal place of business in  
17 another state;

18 (b) The third party administrator is not soliciting business as a third  
19 party administrator in this state; and

20 (c) In the case of any group policy or plan of insurance serviced by the  
21 third party administrator, the lesser of five percent or 100 certificate holders  
22 reside in this state.

23 **SECTION 32.** ORS 748.603 is amended to read:

24 748.603. (1) Societies are governed by this chapter and are exempt from  
25 all other provisions of the insurance laws of this state unless expressly des-  
26 ignated therein, or unless specifically made applicable by this chapter.

27 (2) ORS 705.137, 705.139, 731.004 to 731.026, 731.036 to 731.136, 731.146 to  
28 731.156, 731.162, 731.166, 731.170, 731.216 to 731.268, 731.296, 731.324, 731.328,  
29 731.354, 731.356, 731.358, 731.378, 731.380, 731.381, 731.382, 731.385, 731.386,  
30 731.390, 731.394, 731.396, 731.398, 731.402, 731.406, 731.410, 731.422 to 731.434,  
31 731.446 to 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512,

1 731.592, 731.594, 731.730, 731.731, 731.735, 731.737, 731.750, 731.804, 731.844 to  
 2 731.992, 731.870, 732.245, 732.250, 732.320, 732.325, 733.010 to 733.050, 733.080,  
 3 733.140 to 733.210, 733.220, 733.510, 733.652 to 733.658, 733.730 to 733.750,  
 4 [735.600 to 735.650,] 742.001, 742.003, 742.005, 742.007, 742.009, 742.013 to  
 5 742.021, 742.028, 742.038, 742.041, 742.046, 742.051, 742.150 to 742.162 and  
 6 744.700 to 744.740 and ORS chapters 734, 743 and 743A apply to fraternal  
 7 benefit societies to the extent not inconsistent with the express provisions  
 8 of this chapter.

9 (3) For the purposes of this subsection and subsection (2) of this section,  
 10 fraternal benefit societies shall be deemed insurers, and benefit certificates  
 11 issued by fraternal benefit societies shall be deemed policies.

12 (4) Every society authorized to do business in this state shall be subject  
 13 to the provisions of ORS chapter 746 relating to unfair trade practices.  
 14 However, nothing in ORS chapter 746 shall be construed as applying to or  
 15 affecting the right of any society to determine its eligibility requirements for  
 16 membership, or be construed as applying to or affecting the offering of ben-  
 17 efits exclusively to members or persons eligible for membership in the society  
 18 by a subsidiary corporation or affiliated organization of the society.

19 **SECTION 33.** ORS 750.055, as amended by section 3, chapter 21, Oregon  
 20 Laws 2012, is amended to read:

21 750.055. (1) The following provisions of the Insurance Code apply to  
 22 health care service contractors to the extent not inconsistent with the ex-  
 23 press provisions of ORS 750.005 to 750.095:

24 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362,  
 25 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454,  
 26 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620,  
 27 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750,  
 28 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

29 (b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and  
 30 732.517 to 732.592, not including ORS 732.582.

31 (c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to



1 733.680 and 733.695 to 733.780.

2 (d) ORS chapter 734.

3 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162,  
4 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100  
5 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.499, 743.522, 743.523,  
6 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600  
7 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to  
8 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859,  
9 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913, 743.917,  
10 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.058,  
11 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080,  
12 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110,  
13 743A.140, 743A.141, 743A.144, 743A.148, 743A.160, 743A.164, 743A.168,  
14 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190 and 743A.192 and  
15 section 2, chapter 21, Oregon Laws 2012.

16 (f) The provisions of ORS chapter 744 relating to the regulation of in-  
17 surance producers.

18 (g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605,  
19 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660,  
20 746.668, 746.670, 746.675, 746.680 and 746.690.

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

25 [(i) ORS 735.600 to 735.650.]

26 [(j)] (i) ORS 743.680 to 743.689.

27 [(k)] (j) ORS 744.700 to 744.740.

28 [(L)] (k) ORS 743.730 to 743.773.

29 [(m)] (L) ORS 731.485, except in the case of a group practice health  
30 maintenance organization that is federally qualified pursuant to Title XIII  
31 of the Public Health Service Act and that wholly owns and operates an in-

1 house drug outlet.

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

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

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

11 **SECTION 34. The Oregon Health Authority may take any action**  
12 **prior to July 1, 2017, that is necessary to enable the authority to im-**  
13 **plement section 26 of this 2013 Act and to abolish the Oregon Medical**  
14 **Insurance Pool on the operative date specified in section 38 of this 2013**  
15 **Act.**

16

17

## SUNSET OF OREGON

18

### SUPPLEMENTAL REINSURANCE PROGRAM

19

20 **SECTION 35.** ORS 731.509, as amended by section 5 of this 2013 Act, is  
21 amended to read:

22 731.509. (1) The purpose of ORS 731.509, 731.510, 731.511, 731.512 and  
23 731.516 is to protect the interests of insureds, claimants, ceding insurers,  
24 assuming insurers and the public generally. The Legislative Assembly de-  
25 clares that its intent is to ensure adequate regulation of insurers and re-  
26 insurers and adequate protection for those to whom they owe obligations. In  
27 furtherance of that state interest, the Legislative Assembly mandates that  
28 upon the insolvency of an alien insurer or reinsurer that provides security  
29 to fund its United States obligations in accordance with ORS 731.509, 731.510,  
30 731.511, 731.512 and 731.516, the assets representing the security shall be  
31 maintained in the United States and claims shall be filed with and valued

1 by the state insurance commissioner with regulatory oversight, and the as-  
2 sets shall be distributed in accordance with the insurance laws of the state  
3 in which the trust is domiciled that are applicable to the liquidation of do-  
4 mestic United States insurers. The Legislative Assembly declares that the  
5 laws contained in ORS 731.509, 731.510, 731.511, 731.512 and 731.516 are fun-  
6 damental to the business of insurance in accordance with 15 U.S.C. 1011 and  
7 1012.

8 (2) The Director of the Department of Consumer and Business Services  
9 shall not allow credit for reinsurance to a domestic ceding insurer as either  
10 an asset or a reduction from liability on account of reinsurance ceded unless  
11 credit is allowed as provided under ORS 731.508 and unless the reinsurer  
12 meets the requirements of:

- 13 (a) Subsection (3) of this section;
- 14 (b) Subsection (4) of this section;
- 15 (c) Subsections (5) and (8) of this section;
- 16 (d) Subsections (6) and (8) of this section; **or**
- 17 (e) Subsection (7) of this section[; *or*].
- 18 [*(f) Subsection (9) of this section.*]

19 (3) Credit shall be allowed when the reinsurance is ceded to an authorized  
20 assuming insurer that accepts reinsurance of risks, and retains risk thereon  
21 within such limits, as the assuming insurer is otherwise authorized to insure  
22 in this state as provided in ORS 731.508.

23 (4) Credit shall be allowed when the reinsurance is ceded to an assuming  
24 insurer that is accredited as a reinsurer in this state as provided in ORS  
25 731.511. The director shall not allow credit to a domestic ceding insurer if  
26 the accreditation of the assuming insurer has been revoked by the director  
27 after notice and opportunity for hearing.

28 (5) Credit shall be allowed when the reinsurance is ceded to a foreign  
29 assuming insurer or a United States branch of an alien assuming insurer  
30 meeting all of the following requirements:

- 31 (a) The foreign assuming insurer must be domiciled in a state employing

1 standards regarding credit for reinsurance that equal or exceed the standards  
2 applicable under this section. The United States branch of an alien assuming  
3 insurer must be entered through a state employing such standards.

4 (b) The foreign assuming insurer or United States branch of an alien as-  
5 suming insurer must maintain a combined capital and surplus in an amount  
6 not less than \$20,000,000. The requirement of this paragraph does not apply  
7 to reinsurance ceded and assumed pursuant to pooling arrangements among  
8 insurers in the same holding company system.

9 (c) The foreign assuming insurer or United States branch of an alien as-  
10 suming insurer must submit to the authority of the director to examine its  
11 books and records.

12 (6) Credit shall be allowed when the reinsurance is ceded to an assuming  
13 insurer that maintains a trust fund meeting the requirements of this sub-  
14 section and additionally complies with other requirements of this subsection.  
15 The trust fund must be maintained in a qualified United States financial  
16 institution, as defined in ORS 731.510 (1), for the payment of the valid claims  
17 of its United States policyholders and ceding insurers and their assigns and  
18 successors in interest. The assuming insurer must report annually to the di-  
19 rector information substantially the same as that required to be reported on  
20 the annual statement form by ORS 731.574 by authorized insurers, in order  
21 to enable the director to determine the sufficiency of the trust fund. The  
22 following requirements apply to such a trust fund:

23 (a) In the case of a single assuming insurer, the trust fund must consist  
24 of funds in trust in an amount not less than the assuming insurer's liabilities  
25 attributable to reinsurance ceded by United States ceding insurers. In addi-  
26 tion, the assuming insurer must maintain a trusteed surplus of not less than  
27 \$20,000,000.

28 (b) In the case of a group including incorporated and individual unincor-  
29 porated underwriters:

30 (A) For reinsurance ceded under reinsurance agreements with an incep-  
31 tion, amendment or renewal date on or after August 1, 1995, the trust shall

1 consist of a trusteed account in an amount not less than the group's several  
2 liabilities attributable to business ceded by United States domiciled ceding  
3 insurers to any member of the group.

4 (B) For reinsurance ceded under reinsurance agreements with an incep-  
5 tion date on or before July 31, 1995, and not amended or renewed after that  
6 date, notwithstanding the other provisions of ORS 731.509, 731.510, 731.511,  
7 731.512 and 731.516, the trust shall consist of a trusteed account in an  
8 amount not less than the group's several insurance and reinsurance liabil-  
9 ities attributable to business written in the United States.

10 (C) In addition to the trusts described in subparagraphs (A) and (B) of  
11 this paragraph, the group shall maintain in trust a trusteed surplus of which  
12 \$100,000,000 shall be held jointly for the benefit of the United States  
13 domiciled ceding insurers of any member of the group for all years of ac-  
14 count.

15 (D) The incorporated members of the group shall not be engaged in any  
16 business other than underwriting as a member of the group and shall be  
17 subject to the same level of regulation and solvency control by the group's  
18 domiciliary regulator as are the unincorporated members.

19 (E) Within 90 days after the group's financial statements are due to be  
20 filed with the group's domiciliary regulator, the group shall provide to the  
21 director an annual certification by the group's domiciliary regulator of the  
22 solvency of each underwriter member or, if certification is unavailable, fi-  
23 nancial statements of each underwriter member of the group prepared by  
24 independent certified public accountants.

25 (c) In the case of a group of incorporated insurers described in this par-  
26 agraph, the trust must be in an amount equal to the group's several liabil-  
27 ities attributable to business ceded by United States ceding insurers to any  
28 member of the group pursuant to reinsurance contracts issued in the name  
29 of the group. This paragraph applies to a group of incorporated insurers  
30 under common administration that complies with the annual reporting re-  
31 quirements contained in this subsection and that has continuously transacted

1 an insurance business outside the United States for at least three years im-  
2 mediately prior to making application for accreditation. Such a group must  
3 have an aggregate policyholders' surplus of \$10,000,000,000 and must submit  
4 to the authority of this state to examine its books and records and bear the  
5 expense of the examination. The group shall also maintain a joint trusteed  
6 surplus of which \$100,000,000 must be held jointly for the benefit of United  
7 States ceding insurers of any member of the group as additional security for  
8 any such liabilities. Each member of the group shall make available to the  
9 director an annual certification of the member's solvency by the member's  
10 domiciliary regulator and its independent certified public accountant.

11 (d) The form of the trust and any amendment to the trust shall have been  
12 approved by the insurance commissioner of the state in which the trust is  
13 domiciled or by the insurance commissioner of another state who, pursuant  
14 to the terms of the trust instrument, has accepted principal regulatory  
15 oversight of the trust.

16 (e) The form of the trust and any trust amendments also shall be filed  
17 with the insurance commissioner of every state in which the ceding insurer  
18 beneficiaries of the trust are domiciled. The trust instrument must provide  
19 that contested claims shall be valid and enforceable upon the final order of  
20 any court of competent jurisdiction in the United States. The trust must vest  
21 legal title to its assets in its trustees for the benefit of the assuming  
22 insurer's United States ceding insurers and their assigns and successors in  
23 interest. The trust and the assuming insurer are subject to examination as  
24 determined by the director. The trust must remain in effect for as long as  
25 the assuming insurer has outstanding obligations due under the reinsurance  
26 agreements subject to the trust.

27 (f) Not later than March 1 of each year, the trustees of each trust shall  
28 report to the director in writing the balance of the trust and listing the  
29 trust's investments at the preceding year end, and shall certify the date of  
30 termination of the trust, if so planned, or certify that the trust will not ex-  
31 pire prior to the following December 31.

1 (7) Credit shall be allowed when the reinsurance is ceded to an assuming  
2 insurer not meeting the requirements of subsection (3), (4), (5) or (6) of this  
3 section, but only as to the insurance of risks located in jurisdictions in  
4 which the reinsurance is required by applicable law or regulation of that  
5 jurisdiction.

6 (8) If the assuming insurer is not authorized to transact insurance in this  
7 state or accredited as a reinsurer in this state, the director shall not allow  
8 the credit permitted by subsections (5) and (6) of this section unless the as-  
9 suming insurer agrees in the reinsurance agreement to the provisions stated  
10 in this subsection. This subsection is not intended to conflict with or over-  
11 ride the obligation of the parties to a reinsurance agreement to arbitrate  
12 their disputes, if such an obligation is created in the agreement. The as-  
13 suming insurer must agree in the reinsurance agreement:

14 (a) That in the event of the failure of the assuming insurer to perform its  
15 obligations under the terms of the reinsurance agreement, the assuming  
16 insurer, at the request of the ceding insurer, shall submit to the jurisdiction  
17 of any court of competent jurisdiction in any state of the United States, will  
18 comply with all requirements necessary to give the court jurisdiction and  
19 will abide by the final decision of the court or of any appellate court in the  
20 event of an appeal; and

21 (b) To designate the director or a designated attorney as its true and  
22 lawful attorney upon whom any lawful process in any action, suit or pro-  
23 ceeding instituted by or on behalf of the ceding company may be served.

24 [(9) *Credit shall be allowed when the reinsurance is ceded to the Oregon*  
25 *Supplemental Reinsurance Program established in section 1 of this 2013 Act.*]

26 [(10)] (9) If the assuming insurer does not meet the requirements of sub-  
27 section (3), (4) or (5) of this section, the credit permitted by subsection (6)  
28 of this section shall not be allowed unless the assuming insurer agrees in the  
29 trust agreements to the following conditions:

30 (a) Notwithstanding any other provisions in the trust instrument, if the  
31 trust fund is inadequate because it contains an amount less than the appli-

1 cable amount required by subsection (6)(a), (b) or (c) of this section, or if the  
2 grantor of the trust has been declared insolvent or placed into receivership,  
3 rehabilitation, liquidation or similar proceedings under the laws of the  
4 grantor's state or country of domicile, the trustee shall comply with an order  
5 of the insurance commissioner with regulatory oversight over the trust or  
6 with an order of a court of competent jurisdiction directing the trustee to  
7 transfer to the insurance commissioner with regulatory oversight all the as-  
8 sets of the trust fund.

9 (b) The assets shall be distributed by and claims shall be filed with and  
10 valued by the insurance commissioner with regulatory oversight in accord-  
11 ance with the laws of the state in which the trust is domiciled that are ap-  
12 plicable to the liquidation of domestic insurance companies.

13 (c) If the insurance commissioner with regulatory oversight determines  
14 that the assets of the trust fund or any part thereof are not necessary to  
15 satisfy the claims of the United States ceding insurers of the grantor of the  
16 trust, the assets or part thereof shall be returned by the insurance commis-  
17 sioner according to the laws of that state and according to the terms of the  
18 trust agreement not inconsistent with the laws of that state.

19 (d) The grantor shall waive any right otherwise available to it under  
20 United States law that is inconsistent with this subsection.

21

22

### CONFORMING AMENDMENTS

23

24 **SECTION 36.** ORS 743.769 is amended to read:

25 743.769. (1) Each carrier shall actively market all individual health bene-  
26 fit plans sold by the carrier.

27 (2) Except as provided in subsection (3) of this section, no carrier or in-  
28 surance producer shall, directly or indirectly, discourage an individual from  
29 filing an application for coverage because of the health status, claims expe-  
30 rience, occupation or geographic location of the individual.

31 (3) Subsection (2) of this section does not apply with respect to informa-



1 tion provided by a carrier to an individual regarding the established ge-  
2 ographic service area or a restricted network provision of a carrier.

3 (4) Rejection by a carrier of an application for coverage shall be in writ-  
4 ing and shall state the reason or reasons for the rejection.

5 (5) The Director of the Department of Consumer and Business Services  
6 may establish by rule additional standards to provide for the fair marketing  
7 and broad availability of individual health benefit plans.

8 (6) A carrier that elects to discontinue offering all of its individual health  
9 benefit plans under ORS 743.766 [(5)(c)] (4)(c) or to discontinue offering and  
10 renewing all such plans is prohibited from offering and renewing health  
11 benefit plans in the individual market in this state for a period of five years  
12 from the date of notice to the director pursuant to ORS 743.766 [(5)(c)] (4)(c)  
13 or, if such notice is not provided, from the date on which the director pro-  
14 vides notice to the carrier that the director has determined that the carrier  
15 has effectively discontinued offering individual health benefit plans in this  
16 state. This subsection does not apply with respect to a health benefit plan  
17 discontinued in a specified service area by a carrier that covers services  
18 provided only by a particular organization of health care providers or only  
19 by health care providers who are under contract with the carrier.

20

21

## CAPTIONS

22

23 **SECTION 37. The unit captions used in this 2013 Act are provided**  
24 **only for the convenience of the reader and do not become part of the**  
25 **statutory law of this state or express any legislative intent in the**  
26 **enactment of this 2013 Act.**

27

28

## OPERATIVE DATES AND REPEALS

29

30 **SECTION 38. (1) Sections 1, 2 and 4 of this 2013 Act and the**  
31 **amendments to statutes and session law by sections 5 to 25 and 36 of**

1 **this 2013 Act become operative January 1, 2014.**

2 **(2) Section 26 of this 2013 Act and the amendments to statutes by**  
3 **sections 29 to 33 and 35 of this 2013 Act become operative July 1, 2017.**

4 **SECTION 39. (1) ORS 414.868, 414.872, 735.614, 735.640 and 746.222 and**  
5 **section 1, chapter 803, Oregon Laws 2009, are repealed January 1, 2014.**

6 **(2) Sections 1, 2 and 4 of this 2013 Act and ORS 414.866, 414.870,**  
7 **735.600, 735.605, 735.610, 735.612, 735.615, 735.616, 735.620, 735.625, 735.630,**  
8 **735.635, 735.645 and 735.650 are repealed July 1, 2017.**

9

10

**EMERGENCY CLAUSE**

11

12 **SECTION 40. This 2013 Act being necessary for the immediate**  
13 **preservation of the public peace, health and safety, an emergency is**  
14 **declared to exist, and this 2013 Act takes effect on its passage.**

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