Enrolled
House Bill 3458

Sponsored by COMMITTEE ON HEALTH CARE

CHAPTER .....

AN ACT

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

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

ESTABLISHMENT OF THE OREGON REINSURANCE PROGRAM

SECTION 1. The Oregon Reinsurance Program is established in the Oregon Health Authority. The program shall be administered by the Oregon Medical Insurance Pool Board, created in ORS 735.610, for the purposes of stabilizing the rates and premiums for individual health benefit plans and providing greater financial certainty to consumers of health insurance in this state by providing state reinsurance payments to insurers from assessments described in section 2 of this 2013 Act.

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

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

(b) "Insurer" means an insurer described in ORS 735.605 (4)(a), (b) and (d).

(c) "Program" means the Oregon Reinsurance Program established in section 1 of this 2013 Act.

(d) "Reinsurance eligible health benefit plan" means a health benefit plan providing individual coverage that:

(A) Is delivered or issued for delivery in this state;

(B) Is not a grandfathered health plan as defined in ORS 743.730; and

(C) Meets the criteria prescribed by the Oregon Medical Insurance Pool Board under subsection (2) of this section.

(e) "Reinsurance eligible individual" means an individual who is insured on or before April 1, 2014, under a reinsurance eligible health benefit plan and who, on December 31, 2013, was:

(A) Enrolled in the Oregon Medical Insurance Pool created in ORS 735.610 or the Temporary High Risk Pool Program established in section 1, chapter 47, Oregon Laws 2010;

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

(C) Reinsured under the reinsurance program for children's coverage described in ORS 735.614 (1)(b).

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

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

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

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

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

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

(3) An issuer of a reinsurance eligible health benefit plan becomes eligible for a reinsurance payment when the claims costs for a reinsurance eligible individual's covered benefits in a calendar year exceed the attachment point. The amount of the payment shall be the product of the coinsurance rate and the issuer's claims costs for the reinsurance eligible individual's claims costs that exceed the attachment point, up to the reinsurance cap, as follows:

(a) For 2014:

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

(B) The reinsurance cap is $300,000.

(C) Except as provided in paragraph (b) of this subsection, the coinsurance rate is:

(i) Ten percent for claims costs above $60,000 and up to and including $250,000; and

(ii) Ninety percent for claims costs from $30,000 and up to and including $60,000 and above $250,000.

(b) The board may lower the coinsurance rate if the reinsurance claims incurred exceed the total amount of the assessments collected under subsection (4) of this section.

(c) The board shall adopt by rule an attachment point, reinsurance cap and coinsurance rate for calendar years 2015 and 2016 that complement the federal reinsurance program requirements, so that the reinsurance claims do not exceed the total amount of the assessments collected under subsection (4) of this section. After the rules required under this paragraph are adopted for a calendar year, the board may not:

(A) Change the attachment point or the reinsurance cap adopted for that calendar year; or

(B) Increase the coinsurance rate adopted for that calendar year.

(4) The board shall impose an assessment on all insurers at a rate that is expected to produce an amount of funds sufficient to pay administrative expenses and to make reinsurance payments that are due to issuers of reinsurance eligible health benefit plans in a calendar year, but not greater than the rate that would be expected to produce funds totaling the lesser of:

(a) An amount per month multiplied by the number of insureds and certificate holders in this state who are insured or reinsured; or

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

(5) The amount per month and total assessment on all insurers are as follows:

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

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

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

(6) In determining the number of insureds and certificate holders in this state who are insured or reinsured, the board shall exclude individuals with the following types of coverage:

(a) The medical assistance program under ORS chapter 414;

(b) Medicare;

(c) Disability income insurance;

(d) Hospital-only insurance;

(e) Dental-only insurance;

(f) Vision-only insurance;

(g) Accident-only insurance;

(h) Automobile insurance;

(i) Specific disease insurance;

(j) Medical supplemental plans;

(k) TRICARE;

(L) Prescription drug only plans;

(m) Long term care insurance; and

(n) Federal Employees Health Benefits Program.

(7) If the board collects assessments that exceed the amount necessary to pay administrative expenses and to make all of the reinsurance payments that are due to issuers of reinsurance eligible health benefit plans in calendar years 2014, 2015 and 2016, the board shall refund the excess, on a pro rata basis, to insurers who are subject to the assessment imposed by subsection (4) of this section.

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

(9) All moneys received or collected by the board under this section shall be paid into the Oregon Medical Insurance Pool Account established in ORS 735.612.

(10) The board, in consultation with the Department of Consumer and Business Services, may adopt rules necessary to carry out the provisions of this section including, but not limited to, rules prescribing:

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

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

(c) The amount, manner and frequency of the payment and collection of assessments;

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

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

SECTION 3. Sections 4 and 4a of this 2013 Act are added to and made a part of the Insurance Code.

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

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

(b) "Oregon Medical Insurance Pool Board" means the board created in ORS 735.610.

(c) "Oregon Reinsurance Program" means the program created in section 1 of this 2013 Act.

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

(2) An insurer that offers a health benefit plan must report to the Oregon Medical Insurance Pool Board, in the form and manner prescribed by the board by rule, information about reinsurance eligible individuals insured by the health benefit plan, as necessary for the board to calculate reinsurance payments under the Oregon Reinsurance Program.

SECTION 4a. In a rate filing under ORS 743.018, an insurer must identify the impact of:

(1) State reinsurance payments under section 2 of this 2013 Act and federal reinsurance payments on projected claims costs and in the development of rates; and

(2) Assessments imposed under section 2 of this 2013 Act on rates.

SECTION 5. ORS 731.509 is amended to read:

731.509. (1) The purpose of ORS 731.509, 731.510, 731.511, 731.512 and 731.516 is to protect the interests of insureds, claimants, ceding insurers, assuming insurers and the public generally. The

Legislative Assembly declares that its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislative Assembly mandates that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations in accordance with ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurers. The Legislative Assembly declares that the laws contained in ORS 731.509, 731.510, 731.511, 731.512 and 731.516 are fundamental to the business of insurance in accordance with 15 U.S.C. 1011 and 1012.

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

(a) Subsection (3) of this section;

(b) Subsection (4) of this section;

(c) Subsections (5) and (8) of this section;

(d) Subsections (6) and (8) of this section; [*or*]

(e) Subsection (7) of this section[.]**; or**

(f) Subsection (9) of this section.

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

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

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

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

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

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

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

(a) In the case of a single assuming insurer, the trust fund must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United

States ceding insurers. In addition, the assuming insurer must maintain a trusteed surplus of not less than $20,000,000.

(b) In the case of a group including incorporated and individual unincorporated underwriters:

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

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

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

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

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

(c) In the case of a group of incorporated insurers described in this paragraph, the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group. This paragraph applies to a group of incorporated insurers under common administration that complies with the annual reporting requirements contained in this subsection and that has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation. Such a group must have an aggregate policyholders' surplus of $10,000,000,000 and must submit to the authority of this state to examine its books and records and bear the expense of the examination. The group shall also maintain a joint trusteed surplus of which $100,000,000 must be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities. Each member of the group shall make available to the director an annual certification of the member's solvency by the member's domiciliary regulator and its independent certified public accountant.

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

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

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

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

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

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

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

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

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

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

(b) The assets shall be distributed by and claims shall be filed with and valued by the insurance commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

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

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

SECTION 6. ORS 735.610 is amended to read:

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

(2)**(a)** The board shall consist of [*10*] **12** individuals, [*eight*] **10** of whom shall be appointed by the Director of the Oregon Health Authority. The Director of the Department of Consumer and Business Services or the director's designee and the Director of the Oregon Health Authority or the director's designee shall be members of the board. The chair of the board shall be elected from among the members of the board. The board shall at all times, to the extent possible, include at least**:**

(A) One representative of a domestic insurance company licensed to transact health insurance[,]**;**

(B) One representative of a domestic not-for-profit health care service contractor[,]**;**

(C) One representative of a health maintenance organization[,]**;**

(D) One representative of reinsurers**;** and

(E) [*two*] **Four** members of the general public**:**

(i) Who are not associated with the medical profession, a hospital or an insurer[.]**; and**

(ii) Two of whom represent businesses that purchase health insurance coverage that is subject to the assessments under section 2 of this 2013 Act.

(b) A majority of the voting members of the board constitutes a quorum for the transaction of business. An act by a majority of a quorum is an official act of the board.

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

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

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

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

(c) Take such legal action as is necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

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

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

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

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

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

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

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

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

SECTION 7. ORS 735.630 is amended to read:

735.630. Neither participation in the **Oregon Medical Insurance** Pool **or the Oregon Reinsurance Program** as members, the establishment of rates, forms or procedures, nor any other action taken in the performance of the powers and duties under ORS 735.600 to 735.650 **and sections 1, 2 and 4 of this 2013 Act,** shall be the basis of any legal action, criminal or civil liability or penalty against the Oregon Medical Insurance Pool Board, any members, the Director of the

Oregon Health Authority**, the Director of the Department of Consumer and Business Services** or any of their agents or employees.

SECTION 8. ORS 735.635 is amended to read:

735.635. The **Oregon Medical Insurance** Pool established pursuant to ORS 735.600 to 735.650 **and the Oregon Reinsurance Program established in section 1 of this 2013 Act** shall be exempt from any and all taxes assessed by the State of Oregon.

TERMINATION OF OREGON MEDICAL INSURANCE POOL COVERAGE

SECTION 9. ORS 291.055 is amended to read:

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

(a) Are not effective for agencies in the executive department of government unless approved in writing by the Director of the Oregon Department of Administrative Services;

(b) Are not effective for agencies in the judicial department of government unless approved in writing by the Chief Justice of the Supreme Court;

(c) Are not effective for agencies in the legislative department of government unless approved in writing by the President of the Senate and the Speaker of the House of Representatives;

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

(e) Are rescinded on adjournment sine die of the next regular session of the Legislative Assembly as described in this subsection, unless otherwise authorized by enabling legislation setting forth the approved fees.

(2) This section does not apply to:

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

(b) Taxes or other payments made or collected from employers for unemployment insurance required by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

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

(B) Assessments [*and premiums paid to*] **imposed by** the Oregon Medical Insurance Pool [*established by ORS 735.614 and 735.625*] **Board under section 2 of this 2013 Act**.

(C) Copayments and premiums paid to the Oregon medical assistance program.

(D) Assessments paid to the Department of Consumer and Business Services under ORS 743.951 and 743.961.

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

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

(f) Any intergovernmental charges.

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

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

(i) Any charges established by the State Parks and Recreation Director in accordance with ORS 565.080 (3).

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

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

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

(m) New or increased fees that are anticipated in the legislative budgeting process for an agency, revenues from which are included, explicitly or implicitly, in the legislatively adopted budget or the legislatively approved budget for the agency.

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

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

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

(A) The reason for the fee decrease; and

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

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

SECTION 10. ORS 414.841 is amended to read:

414.841. For purposes of ORS 414.841 to 414.864:

(1) "Carrier" has the meaning given that term in ORS 735.700.

(2) "Dental plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement only for the expenses of dental care.

(3) "Eligible individual" means an individual who:

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

(b) Is not eligible for Medicare;

(c) Is either:

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

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

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

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

(4) "Family" means an eligible individual and all other related individuals, as prescribed by the office by rule.

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

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long

term care insurance, hospital indemnity only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.

(6) "Income" means gross income in cash or kind available to the applicant or the applicant's family. Income does not include earned income of the applicant's children or income earned by a spouse if there is a legal separation.

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

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

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

SECTION 11. ORS 705.145 is amended to read:

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

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

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

(4) Moneys in the fund are continuously appropriated to the department for its administrative expenses and for its expenses in carrying out its functions and duties under any provision of law.

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

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

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

(a) Pay compensation benefits; and

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

(8) Notwithstanding subsections (2), (3) and (5) of this section and except as provided in ORS 455.220 (1), the moneys derived pursuant to ORS 446.003 to 446.200, 446.210, 446.225 to 446.285, 446.395 to 446.420, 446.566 to 446.646, 446.661 to 446.756 and 455.220 (1) and deposited to the fund, interest earned on those moneys and withdrawals of moneys for activities or programs under ORS

446.003 to 446.200, 446.210, 446.225 to 446.285, 446.395 to 446.420, 446.566 to 446.646 and 446.661 to 446.756, or education and training programs pertaining thereto, must be assigned to a single account within the fund.

(9) Notwithstanding subsections (2), (3) and (5) of this section, the moneys derived pursuant to ORS 455.240 or 460.370 or from state building code or specialty code program fees for which the amount is established by department rule pursuant to ORS 455.020 (2) and deposited to the fund, interest earned on those moneys and withdrawals of moneys for activities or programs described under ORS 455.240 or 446.566 to 446.646, 446.661 to 446.756 and 460.310 to 460.370, structural or mechanical specialty code programs or activities for which a fee is collected under ORS 455.020 (2), or programs described under subsection (10) of this section that provide training and education for persons employed in producing, selling, installing, delivering or inspecting manufactured structures or manufactured dwelling parks or recreation parks, must be assigned to a single account within the fund.

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

SECTION 12. ORS 731.036 is amended to read:

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

(1) A bail bondsman, other than a corporate surety and its agents.

(2) A fraternal benefit society that has maintained lodges in this state and other states for 50 years prior to January 1, 1961, and for which a certificate of authority was not required on that date.

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

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

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

(6) Cities, counties, school districts, community college districts, community college service districts or districts, as defined in ORS 198.010 and 198.180, that either individually or jointly insure for health insurance coverage, excluding disability insurance, their employees or retired employees, or their dependents, or students engaged in school activities, or combination of employees and dependents, with or without employee or student contributions, if all of the following conditions are met:

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

(A) In the case of a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals;

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

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

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

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

(d) Enrollees must be provided copies of summary plan descriptions including:

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

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

(C) Other group health plan enrollee rights, disclosure or written procedure requirements established under ORS chapters 743 and 743A;

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

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

(B) The program must maintain adequate reserves. Reserves may be invested in accordance with the provisions of ORS chapter 293. Reserve adequacy must be calculated annually with proper actuarial calculations including the following:

(i) Known claims, paid and outstanding;

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

(iii) Claims handling expenses;

(iv) Unearned contributions; and

(v) A claims trend factor; and

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

(f) The individual or jointly self-insured program must have sufficient personnel to service the employee benefit program or must contract with a third party administrator licensed under ORS chapter 744 as a third party administrator to provide such services;

(g) The individual or jointly self-insured program shall be subject to assessment in accordance with [*ORS 735.614 and former enrollees shall be eligible for portability coverage in accordance with ORS 735.616*] **section 2 of this 2013 Act**;

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

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

(7) All ambulance services.

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

(a) Towing service.

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

(c) Transportation and arrangements for the transportation of human remains, including all necessary and appropriate preparations for and actual transportation provided to return a decedent's remains from the decedent's place of death to a location designated by a person with valid legal authority under ORS 97.130.

(9)(a) A person described in this subsection who, in an agreement to lease or to finance the purchase of a motor vehicle, agrees to waive for no additional charge the amount specified in paragraph (b) of this subsection upon total loss of the motor vehicle because of physical damage, theft

or other occurrence, as specified in the agreement. The exemption established in this subsection applies to the following persons:

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

(B) The lessor of the motor vehicle.

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

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

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

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

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

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

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

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

(C) A partnership or limited liability company that is engaged in providing affordable housing and that is affiliated with a housing authority described in subparagraph (A) of this paragraph or a nonprofit corporation described in subparagraph (B) of this paragraph if the housing authority or nonprofit corporation:

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

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

(iii) Has entered into a contract to lease, manage or operate the affordable housing owned by the partnership or limited liability company; or

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

(11) A community-based health care initiative approved by the Administrator of the Office for Oregon Health Policy and Research under ORS 735.723 operating a community-based health care improvement program approved by the administrator.

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

SECTION 13. ORS 734.790 is amended to read:

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

(a) To a person who is a resident, if the person is an owner of or a certificate holder under the policy or contract other than a structured settlement annuity or, in the case of an unallocated annuity contract, an employee participating in a governmental retirement plan established under section 401, 403(b) or 457 of the United States Internal Revenue Code or the beneficiaries of each such individual if deceased.

(b) To a person who is not a resident, if the person is an owner of or a certificate holder under the policy or contract other than a structured settlement annuity or, in the case of an unallocated annuity contract, an employee participating in a governmental retirement plan established under section 401, 403(b) or 457 of the United States Internal Revenue Code or the beneficiaries of each

such individual if deceased. This paragraph applies to a person who is not a resident only if all of the following conditions are met:

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

(B) The state in which the person resides must have an association similar to the Oregon Life and Health Insurance Guaranty Association.

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

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

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

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

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

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

(ii) Neither the payee or beneficiary nor the contract owner of the structured settlement annuity is eligible for coverage by the association of the state in which the payee or contract owner resides.

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

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

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

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

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

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

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

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

(B) Exceeds, on and after the date on which the member insurer becomes either an impaired or insolvent insurer under ORS 734.750 to 734.890, whichever occurs first, the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available.

(f) Any portion of a policy or contract issued to a plan or program of an employer, association or similar entity to provide life insurance, health insurance or annuity benefits to its employees or

members to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association or similar entity under any of the following:

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

(B) A minimum premium group insurance plan.

(C) A stop-loss group insurance plan.

(D) An administrative services only contract.

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

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

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

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

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

[*(L)*] **(k)** Any portion of a policy or contract to the extent that the assessments required by ORS 734.815 with respect to the policy or contract are preempted by federal or state law.

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

(A) Claims based on marketing materials;

(B) Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy or contract form filing or approval requirements;

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

(D) Extracontractual claims, including but not limited to claims related to bad faith in the payment of claims, punitive or exemplary damages or attorney fees or costs; or

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

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

[*(o)*] **(n)** Any portion of a policy or contract to the extent that portion provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but the changes in value have not been credited to the policy or contract, or as to which the policyholder's or contract owner's rights are subject to forfeiture, as of the date on which the member insurer becomes either an impaired or insolvent insurer, whichever occurs first. If the interest or changes in value in a policy or contract are credited less frequently than annually, for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, the interest or change in value that is determined by using the procedures specified in the policy or contract shall be credited as if the contractual date of crediting interest or changing value was the date of the impairment or insolvency, whichever is earlier, and may not be subject to forfeiture.

[*(p)*] **(o)** Any policy or contract providing any hospital, medical, prescription drug or other health care benefits under Part C or Part D of subchapter XVIII, chapter 7, Title 42 of the United States Code, or any regulations issued under those provisions.

(4) As used in this section, "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

SECTION 14. ORS 735.612 is amended to read:

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

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

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

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

(2) All moneys in the Oregon Medical Insurance Pool Account are continuously appropriated to the Oregon Medical Insurance Pool Board to carry out the provisions of ORS 735.600 to 735.650 **and sections 1, 2 and 4 of this 2013 Act**.

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

SECTION 15. ORS 735.616 is amended to read:

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

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

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

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

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

(b) An eligible individual, as defined in ORS 743.760, who has left coverage under a group health benefit plan or a portability health benefit plan and whose carrier cannot offer a portability plan under ORS 743.760 (6) because of:

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

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

(C) The carrier's withdrawal from the group market in Oregon in accordance with ORS 743.737 and 743.754;

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

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

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

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

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

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

(a) An eligible individual does not include:

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

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

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

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

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

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

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

(4) Coverage under the Oregon Medical Insurance Pool pursuant to subsections (1) and (2) of this section shall be offered according to the following provisions:

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

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

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

SECTION 16. ORS 735.625 is amended to read:

735.625. (1) Except as provided in subsection (3)(c) of this section, the Oregon Medical Insurance Pool Board shall offer major medical expense coverage to every eligible person**. The board may not offer coverage under this section after December 31, 2013**.

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

(3)(a) In establishing portability coverage under the pool, the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations that the board determines are equivalent to the portability health benefit plans established under ORS 743.760.

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

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

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

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

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

(c) The board shall determine the applicable medical and portability risk rates either by calculating the average rate charged by insurers offering coverages in the state comparable to the pool coverage or by using reasonable actuarial techniques. The risk rates shall reflect anticipated experience and expenses for such coverage. Rates for pool coverage may not be more than 125 percent of rates established as applicable for medically eligible individuals or for persons eligible for pool coverage under ORS 735.615 (1)(d), or 100 percent of rates established as applicable for portability eligible individuals.

(d) The board shall annually determine adjusted benefits and premiums. The adjustments shall be in keeping with the purposes of ORS 735.600 to 735.650, subject to a limitation of keeping pool losses under one percent of the total of all medical insurance premiums, subscriber contract charges and 110 percent of all benefits paid by member self-insurance arrangements. The board may determine the total number of persons that may be enrolled for coverage at any time and may permit and prohibit enrollment in order to maintain the number authorized. Nothing in this paragraph authorizes the board to prohibit enrollment for any reason other than to control the number of persons in the pool.

(5)(a) The board may apply:

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

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

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

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

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

(6)(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or self-insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except the Medicaid portion of the medical assistance program offering a level of health services described in ORS 414.707.

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

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

(8) Pool coverage may be furnished through a health care service contractor or such alternative delivery system as will contain costs while maintaining quality of care.

SECTION 17. ORS 735.645 is amended to read:

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

SECTION 18. ORS 735.650 is amended to read:

735.650. [*(1)*] The following provisions of the Insurance Code shall apply to the pool to the extent applicable and not inconsistent with the express provisions of ORS 735.600 to 735.650: ORS 731.004 to 731.022, 731.052 to 731.146, 731.162, 731.216 to 731.328, 742.023, 742.028, 742.046, 742.051, 742.056, 743.024, 743.027, 743.028, 743.041, 743.050, 743.100 to 743.106, 743.402, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.834, 743.837, 743.839, 743.845, 743A.084, 743A.090, 746.005 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

SECTION 19. ORS 743.402 is amended to read:

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

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

(2) Any policy of reinsurance;

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

(4) Any life insurance policy, or policy supplemental thereto which contains only such provisions relating to health insurance as:

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

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

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

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

743.730. For purposes of ORS 743.730 to 743.773:

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

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

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

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee in lieu of a preexisting condition exclusion;

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

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

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

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

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

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

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

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

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

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

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

(8) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon Health Insurance Exchange.

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

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

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

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

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

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

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

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

(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

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

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

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

(B) Individual health benefit plans; or

(C) Portability health benefit plans.

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

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

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

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

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

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

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

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

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

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

(C) Medicare supplement insurance policies;

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

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

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

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

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

(I) Dental only coverage;

(J) Vision only coverage;

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

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

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

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

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

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

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

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

(23) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

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

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

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

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

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

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

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

(26) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

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

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

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

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

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

[*(29)*] **(28)** "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

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

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

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

[*(33)(a)*] **(32)(a)** "Small employer" means an employer that employed an average of at least two but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least two eligible employees on the date on which coverage takes effect under a health benefit plan offered by the employer.

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

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

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

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

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

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

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

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

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

(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses and the assessment against the carrier for the Oregon [*Medical Insurance Pool*] **Reinsurance Program**;

(B) The total amount of the surplus maintained;

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

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

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

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

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

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) If the carrier elects to restrict coverage through the application of a preexisting condition exclusion or an individual coverage waiting period provision, the carrier shall reduce the duration

of the provision by an amount equal to the individual's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days after the effective date of coverage in the new individual health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 23. ORS 743.767 is amended to read:

743.767. Premium rates for individual health benefit plans shall be subject to the following provisions:

(1) Each carrier must file the carrier's initial geographic average rate and any changes to the geographic average rate for its individual health benefit plans with the Director of the Department of Consumer and Business Services.

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

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

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

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

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

SECTION 24. ORS 746.600 is amended to read:

746.600. As used in ORS 746.600 to 746.690:

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

(A) A declination of insurance coverage.

(B) A termination of insurance coverage.

(C) Failure of an insurance producer to apply for insurance coverage with a specific insurer that the insurance producer represents and that is requested by an applicant.

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

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

(i) Placement by an insurer or insurance producer of a risk with a residual market mechanism, an unauthorized insurer or an insurer that specializes in substandard risks.

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

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

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

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

(B) A declination of insurance coverage solely because the coverage is not available on a class or statewide basis.

(C) The rescission of a policy.

(2) "Affiliate of" a specified person or "person affiliated with" a specified person means a person who directly, or indirectly, through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(3) "Applicant" means a person who seeks to contract for insurance coverage, other than a person seeking group insurance coverage that is not individually underwritten.

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

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

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

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

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

(c) Furnishes consumer reports to other persons.

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

(8) "Covered entity" means:

(a) A health insurer;

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

(c) A health care clearinghouse.

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

(a) Bears on a consumer's creditworthiness, credit standing or credit capacity; and

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

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

(11) "Declination of insurance coverage" or "decline coverage" means a denial, in whole or in part, by an insurer or insurance producer of an application for requested insurance coverage.

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

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

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

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

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating deidentified information; and

(j) Fundraising.

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

(a) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

(b) A physician, podiatric physician and surgeon, physician assistant or acupuncturist licensed under ORS chapter 677 or an employee of the physician, podiatric physician and surgeon, physician assistant or acupuncturist;

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

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

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

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

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

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

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

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

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

(o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory care practitioner;

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

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

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

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

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

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

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

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

(x) A pharmacy as defined in ORS 689.005;

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

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

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

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

(b) Relates to:

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

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

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

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

[*(a)*] an insurer who offers:

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

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

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

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

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

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

(17) "Homeowner insurance" means insurance for residential property consisting of a combination of property insurance and casualty insurance that provides coverage for the risks of owning or occupying a dwelling and that is not intended to cover an owner's interest in rental property or commercial exposures.

(18) "Individual" means a natural person who:

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

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

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

(d) Is a past or present applicant;

(e) Is a past or present claimant; or

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

(19) "Individually identifiable health information" means any oral or written health information that is:

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

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

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

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

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

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

(a) An insurance producer;

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

(c) A natural person acting in a personal capacity rather than in a business or professional capacity.

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

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

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

(A) The furnishing of consumer reports to an insurer or insurance producer for use in connection with insurance transactions; and

(B) The collection of personal information from insurers, insurance producers or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

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

(24) "Insurance transaction" means any transaction that involves insurance primarily for personal, family or household needs rather than business or professional needs and that entails:

(a) The determination of an individual's eligibility for an insurance coverage, benefit or payment; or

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

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

(26) "Investigative consumer report" means a consumer report, or portion of a consumer report, for which information about a natural person's character, general reputation, personal characteristics or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances or others who may have knowledge concerning such items of information.

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

(28) "Loss history report" means a report provided by, or a database maintained by, an insurance-support organization or consumer reporting agency that contains information regarding the claims history of the individual property that is the subject of the application for a homeowner insurance policy or the consumer applying for a homeowner insurance policy.

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

(a) An affiliate of a licensee;

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

(c) As designated by the director by rule.

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

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

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

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

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

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

(32) "Personal information" means:

(a) Personal financial information;

(b) Individually identifiable health information; or

(c) Protected health information.

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

(a) Private passenger automobile coverage;

(b) Homeowner, mobile homeowners, manufactured homeowners, condominium owners and renters coverage;

(c) Personal dwelling property coverage;

(d) Personal liability and theft coverage, including excess personal liability and theft coverage; and

(e) Personal inland marine coverage.

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

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

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

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

(d) A person described in ORS 746.611.

(35) "Policyholder" means a person who:

(a) In the case of individual policies of life or health insurance, is a current policyowner;

(b) In the case of individual policies of other kinds of insurance, is currently a named insured; or

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

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

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

(b) Pretends to represent a person the interviewer is not in fact representing.

(c) Misrepresents the true purpose of the interview.

(d) Refuses upon request to identify the interviewer.

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

(a) Relates to a claim for insurance benefits or a civil or criminal proceeding involving the individual; and

(b) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or a civil or criminal proceeding involving the individual.

(38)(a) "Protected health information" means individually identifiable health information that is transmitted or maintained in any form of electronic or other medium by a covered entity.

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

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

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

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

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

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

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

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

(b) Consultations and referrals between health care providers.

TERMINATION OF TEMPORARY HIGH RISK POOL PROGRAM

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

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

ABOLISHMENT OF OREGON MEDICAL INSURANCE POOL BOARD

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

SECTION 27. Before the operative date of section 26 of this 2013 Act, the Oregon Medical Insurance Pool Board shall pay all valid outstanding claims against the Oregon Medical Insurance Pool. Any balances of amounts remaining in the Oregon Medical Insurance Pool

Account after the payment of claims shall be refunded to insurers in a manner determined by the board to be fair and equitable.

SECTION 28. (1) Nothing in section 26 or 27 of this 2013 Act, the amendments to statutes and session law by sections 9 to 25, 29 to 33 and 35 to 39 of this 2013 Act or the repeal of statutes and session law by section 42 of this 2013 Act relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions and powers of the Oregon Medical Insurance Pool Board. The Oregon Health Authority may undertake the collection or enforcement of any such liability, duty or obligation.

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

(3) Notwithstanding the abolishment of the Oregon Medical Insurance Pool by section 26 of this 2013 Act, the rules of the board in effect on the effective date of this 2013 Act continue in effect until superseded or repealed by rules of the authority. References in rules of the board to the board or an officer or employee of the board are considered to be references to the authority or an officer or employee of the authority.

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

SECTION 29. ORS 65.957 is amended to read:

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

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

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

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

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

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

SECTION 30. ORS 192.556 is amended to read:

192.556. As used in ORS 192.553 to 192.581:

(1) "Authorization" means a document written in plain language that contains at least the following:

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

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

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

(d) A description of each purpose of the requested use or disclosure, including but not limited to a statement that the use or disclosure is at the request of the individual;

(e) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;

(f) The signature of the individual or personal representative of the individual and the date;

(g) A description of the authority of the personal representative, if applicable; and

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

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

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

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

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

(2) "Covered entity" means:

(a) A state health plan;

(b) A health insurer;

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

(d) A health care clearinghouse.

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

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

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

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

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating deidentified information; and

(j) Fundraising.

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

(a) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

(b) A physician, podiatric physician and surgeon, physician assistant or acupuncturist licensed under ORS chapter 677 or an employee of the physician, podiatric physician and surgeon, physician assistant or acupuncturist;

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

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

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

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

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

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

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

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

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

(o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory care practitioner;

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

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

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

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

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

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

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

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

(x) A pharmacy as defined in ORS 689.005;

(y) A diabetes self-management program as defined in ORS 743A.184; and

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

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

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

(b) Relates to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

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

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

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

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

(d) A person described in ORS 192.573.

(11)(a) "Protected health information" means individually identifiable health information that is maintained or transmitted in any form of electronic or other medium by a covered entity.

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

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

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

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

(12) "State health plan" means:

(a) Medical assistance as defined in ORS 414.025;

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

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

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

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

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

(b) Consultations and referrals between health care providers.

SECTION 31. ORS 744.704 is amended to read:

744.704. (1) The following persons are exempt from the licensing requirement for third party administrators in ORS 744.702 and from all other provisions of ORS 744.700 to 744.740 applicable to third party administrators:

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

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

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

(A) Its employees;

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

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

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

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

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

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

(h) A trust exempt from taxation under section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to the trust, or a voluntary employees beneficiary association described in section 501(c) of the Internal Revenue Code, its agents and employees and a custodian

and the custodian's agents and employees acting pursuant to a custodian account meeting the requirements of section 401(f) of the Internal Revenue Code.

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

(j) A company that issues credit cards and advances for and collects premiums or charges from its credit card holders who have authorized collection. The exemption under this paragraph applies only if the company does not adjust or settle claims.

(k) A person who adjusts or settles claims in the normal course of practice or employment as an attorney at law. The exemption under this subsection applies only if the person does not collect charges or premiums in connection with life insurance or health insurance coverage.

(L) A person who acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for which the Insurance Code is preempted pursuant to the Employee Retirement Income Security Act of 1974. A person to whom this paragraph applies must comply with the requirements of ORS 744.714.

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

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

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

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

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

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

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

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

SECTION 32. ORS 748.603 is amended to read:

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

(2) ORS 705.137, 705.139, 731.004 to 731.026, 731.036 to 731.136, 731.146 to 731.156, 731.162, 731.166, 731.170, 731.216 to 731.268, 731.296, 731.324, 731.328, 731.354, 731.356, 731.358, 731.378, 731.380, 731.381, 731.382, 731.385, 731.386, 731.390, 731.394, 731.396, 731.398, 731.402, 731.406, 731.410, 731.422 to 731.434, 731.446 to 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.592, 731.594, 731.730, 731.731, 731.735, 731.737, 731.750, 731.804, 731.844 to 731.992, 731.870, 732.245, 732.250, 732.320, 732.325, 733.010 to 733.050, 733.080, 733.140 to 733.210, 733.220, 733.510, 733.652 to 733.658, 733.730 to 733.750, [*735.600 to 735.650,*] 742.001, 742.003, 742.005, 742.007, 742.009, 742.013 to 742.021, 742.028, 742.038, 742.041, 742.046, 742.051, 742.150 to 742.162 and 744.700 to 744.740 and ORS chapters 734, 743 and 743A apply to fraternal benefit societies to the extent not inconsistent with the express provisions of this chapter.

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

(4) Every society authorized to do business in this state shall be subject to the provisions of ORS chapter 746 relating to unfair trade practices. However, nothing in ORS chapter 746 shall be

construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

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

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

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

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

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

(d) ORS chapter 734.

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

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

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

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

[*(i) ORS 735.600 to 735.650.*]

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

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

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

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

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

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

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

SECTION 34. The Oregon Health Authority may take any action prior to July 1, 2017, that is necessary to enable the authority to implement section 26 of this 2013 Act and to abolish the Oregon Medical Insurance Pool on the operative date of section 26 of this 2013 Act, as specified in section 41 of this 2013 Act.

SUNSET OF OREGON REINSURANCE PROGRAM

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

731.509. (1) The purpose of ORS 731.509, 731.510, 731.511, 731.512 and 731.516 is to protect the interests of insureds, claimants, ceding insurers, assuming insurers and the public generally. The Legislative Assembly declares that its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislative Assembly mandates that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations in accordance with ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurers. The Legislative Assembly declares that the laws contained in ORS 731.509, 731.510, 731.511, 731.512 and 731.516 are fundamental to the business of insurance in accordance with 15 U.S.C. 1011 and 1012.

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

(a) Subsection (3) of this section;

(b) Subsection (4) of this section;

(c) Subsections (5) and (8) of this section;

(d) Subsections (6) and (8) of this section; **or**

(e) Subsection (7) of this section[*; or*]**.**

[*(f) Subsection (9) of this section.*]

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

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

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

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

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

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

(6) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund meeting the requirements of this subsection and additionally complies with other requirements of this subsection. The trust fund must be maintained in a qualified United States financial institution, as defined in ORS 731.510 (1), for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer must report annually to the director information substantially the same as that required to

be reported on the annual statement form by ORS 731.574 by authorized insurers, in order to enable the director to determine the sufficiency of the trust fund. The following requirements apply to such a trust fund:

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

(b) In the case of a group including incorporated and individual unincorporated underwriters:

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

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

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

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

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

(c) In the case of a group of incorporated insurers described in this paragraph, the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group. This paragraph applies to a group of incorporated insurers under common administration that complies with the annual reporting requirements contained in this subsection and that has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation. Such a group must have an aggregate policyholders' surplus of $10,000,000,000 and must submit to the authority of this state to examine its books and records and bear the expense of the examination. The group shall also maintain a joint trusteed surplus of which $100,000,000 must be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities. Each member of the group shall make available to the director an annual certification of the member's solvency by the member's domiciliary regulator and its independent certified public accountant.

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

(e) The form of the trust and any trust amendments also shall be filed with the insurance commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to exam-

ination as determined by the director. The trust must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

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

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

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

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

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

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

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

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

(b) The assets shall be distributed by and claims shall be filed with and valued by the insurance commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

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

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

SECTION 36. ORS 291.055, as amended by section 9 of this 2013 Act, is amended to read:

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

(a) Are not effective for agencies in the executive department of government unless approved in writing by the Director of the Oregon Department of Administrative Services;

(b) Are not effective for agencies in the judicial department of government unless approved in writing by the Chief Justice of the Supreme Court;

(c) Are not effective for agencies in the legislative department of government unless approved in writing by the President of the Senate and the Speaker of the House of Representatives;

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

(e) Are rescinded on adjournment sine die of the next regular session of the Legislative Assembly as described in this subsection, unless otherwise authorized by enabling legislation setting forth the approved fees.

(2) This section does not apply to:

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

(b) Taxes or other payments made or collected from employers for unemployment insurance required by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

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

[*(B) Assessments imposed by the Oregon Medical Insurance Pool Board under section 2 of this 2013 Act.*]

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

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

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

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

(f) Any intergovernmental charges.

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

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

(i) Any charges established by the State Parks and Recreation Director in accordance with ORS 565.080 (3).

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

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

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

(m) New or increased fees that are anticipated in the legislative budgeting process for an agency, revenues from which are included, explicitly or implicitly, in the legislatively adopted budget or the legislatively approved budget for the agency.

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

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

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

(A) The reason for the fee decrease; and

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

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

SECTION 37. ORS 731.036, as amended by section 12 of this 2013 Act, is amended to read:

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

(1) A bail bondsman, other than a corporate surety and its agents.

(2) A fraternal benefit society that has maintained lodges in this state and other states for 50 years prior to January 1, 1961, and for which a certificate of authority was not required on that date.

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

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

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

(6) Cities, counties, school districts, community college districts, community college service districts or districts, as defined in ORS 198.010 and 198.180, that either individually or jointly insure for health insurance coverage, excluding disability insurance, their employees or retired employees, or their dependents, or students engaged in school activities, or combination of employees and dependents, with or without employee or student contributions, if all of the following conditions are met:

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

(A) In the case of a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals;

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

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

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

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

(d) Enrollees must be provided copies of summary plan descriptions including:

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

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

(C) Other group health plan enrollee rights, disclosure or written procedure requirements established under ORS chapters 743 and 743A;

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

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

(B) The program must maintain adequate reserves. Reserves may be invested in accordance with the provisions of ORS chapter 293. Reserve adequacy must be calculated annually with proper actuarial calculations including the following:

(i) Known claims, paid and outstanding;

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

(iii) Claims handling expenses;

(iv) Unearned contributions; and

(v) A claims trend factor; and

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

(f) The individual or jointly self-insured program must have sufficient personnel to service the employee benefit program or must contract with a third party administrator licensed under ORS chapter 744 as a third party administrator to provide such services;

[*(g) The individual or jointly self-insured program shall be subject to assessment in accordance with section 2 of this 2013 Act;*]

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

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

(7) All ambulance services.

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

(a) Towing service.

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

(c) Transportation and arrangements for the transportation of human remains, including all necessary and appropriate preparations for and actual transportation provided to return a decedent's remains from the decedent's place of death to a location designated by a person with valid legal authority under ORS 97.130.

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

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

(B) The lessor of the motor vehicle.

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

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

(b) The amount waived pursuant to the agreement shall be the difference, or portion thereof, between the amount received by the seller, lessor, lender or assignee, as applicable, that represents

the actual cash value of the motor vehicle at the date of loss, and the amount owed under the agreement.

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

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

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

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

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

(C) A partnership or limited liability company that is engaged in providing affordable housing and that is affiliated with a housing authority described in subparagraph (A) of this paragraph or a nonprofit corporation described in subparagraph (B) of this paragraph if the housing authority or nonprofit corporation:

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

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

(iii) Has entered into a contract to lease, manage or operate the affordable housing owned by the partnership or limited liability company; or

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

(11) A community-based health care initiative approved by the Administrator of the Office for Oregon Health Policy and Research under ORS 735.723 operating a community-based health care improvement program approved by the administrator.

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

SECTION 38. ORS 743.748, as amended by section 18, chapter 500, Oregon Laws 2011, and section 21 of this 2013 Act, is amended to read:

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

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

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

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

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

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

(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses [*and the assessment against the carrier for the Oregon Reinsurance Program*];

(B) The total amount of the surplus maintained;

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

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

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

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

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

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

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

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

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

CONFORMING AMENDMENTS

SECTION 39. ORS 743.769 is amended to read:

743.769. (1) Each carrier shall actively market all individual health benefit plans sold by the carrier.

(2) Except as provided in subsection (3) of this section, no carrier or insurance producer shall, directly or indirectly, discourage an individual from filing an application for coverage because of the health status, claims experience, occupation or geographic location of the individual.

(3) Subsection (2) of this section does not apply with respect to information provided by a carrier to an individual regarding the established geographic service area or a restricted network provision of a carrier.

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

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

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

CAPTIONS

SECTION 40. The unit captions used in this 2013 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2013 Act.

OPERATIVE DATES AND REPEALS

SECTION 41. (1) Sections 1, 2, 4 and 4a of this 2013 Act and the amendments to statutes and session law by sections 5 to 20, 22 to 25 and 39 of this 2013 Act become operative January 1, 2014.

(2) Section 26 of this 2013 Act and the amendments to statutes by sections 29 to 33 and 35 to 38 of this 2013 Act become operative July 1, 2017.

(3) The amendments to ORS 743.748 by section 21 of this 2013 Act become operative April 2, 2014.

SECTION 42. (1) ORS 414.868, 414.872, 735.614, 735.640 and 746.222 and section 1, chapter 803, Oregon Laws 2009, are repealed January 1, 2014.

(2) Sections 1, 2, 4 and 4a of this 2013 Act and ORS 414.866, 414.870, 735.600, 735.605, 735.610, 735.612, 735.615, 735.616, 735.620, 735.625, 735.630, 735.635, 735.645 and 735.650 are repealed July 1, 2017.

EMERGENCY CLAUSE

SECTION 43. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.

Passed by House May 28, 2013

.....
Ramona J. Line, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate June 20, 2013

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2013

Approved:

.....M.,....., 2013

.....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

.....M.,....., 2013

.....
Kate Brown, Secretary of State