

**PROPOSED AMENDMENTS TO  
HOUSE BILL 2240**

1 On page 1 of the printed bill, line 2, after “ORS” delete the rest of the  
2 line and delete lines 3 through 13 and insert “192.556, 410.080, 413.011,  
3 413.032, 413.201, 414.041, 414.231, 414.826, 414.828, 414.839, 433.443, 731.036,  
4 731.146, 735.625, 741.300, 743.018, 743.019, 743.405, 743.417, 743.420, 743.522,  
5 743.524, 743.526, 743.528, 743.550, 743.552, 743.560, 743.610, 743.730, 743.731,  
6 743.733, 743.734, 743.736, 743.737, 743.745, 743.748, 743.751, 743.752, 743.754,  
7 743.757, 743.766, 743.767, 743.769, 743.777, 743.804, 743.822, 743.894, 743A.090,  
8 743A.168, 743A.192, 746.015 and 746.045 and section 1, chapter 867, Oregon  
9 Laws 2009; repealing ORS 414.831, 414.841, 414.842, 414.844, 414.846, 414.848,  
10 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866,  
11 414.868, 414.870, 414.872, 735.616, 735.700, 735.701, 735.702, 735.703, 735.705,  
12 735.707, 735.709, 735.710, 735.712, 743.549, 743.760 and 743.761; and declaring  
13 an emergency.”.

14 In line 18, delete “5, 6, 7 and 8” and insert “5 and 6”.

15 In line 22, delete “but not limited to”.

16 On page 2, delete lines 9 through 45.

17 On page 3, delete lines 1 through 28 and insert:

18 **“SECTION 3. (1) As used in this section, ‘health benefit plan’ means**  
19 **a health benefit plan, as defined in ORS 743.730, that is offered in the**  
20 **individual or small group market.**

21 **“(2) The Department of Consumer and Business Services may es-**  
22 **tablish by rule a procedure for adjusting risk between insurers. If a**

1 **procedure is established, the procedure may include:**

2 **“(a) An assessment imposed on an insurer if the actuarial risk of**  
3 **the enrollees in the insurer’s health benefit plans is less than the av-**  
4 **erage actuarial risk of all enrollees in all health benefit plans in this**  
5 **state; and**

6 **“(b) Payments to insurers if the actuarial risk of the enrollees in**  
7 **the insurer’s health benefit plans is greater than the average actuarial**  
8 **risk of all enrollees in all health benefit plans in this state.**

9 **“(3) A procedure established under this section must be consistent**  
10 **with 42 U.S.C. 18063 and regulations adopted by the Secretary of the**  
11 **United States Department of Health and Human Services to carry out**  
12 **42 U.S.C. 18063.”.**

13 In line 29, delete “5” and insert “4”.

14 In line 35, delete “6” and insert “5”.

15 In line 43, after the period insert “Any requirements must be designed to  
16 minimize the administrative burden on insurers, including by allowing no-  
17 tices to be combined into one notice, as appropriate.”.

18 Delete lines 44 and 45.

19 On page 4, delete lines 1 through 9 and insert:

20 **“SECTION 6. (1) Notwithstanding ORS 743.737 (8)(d) and 743.767 (3),**  
21 **at one time during the 2014 calendar year, insurers may increase their**  
22 **rates by an amount that reflects:**

23 **“(a) The health insurance providers fee imposed under section 9010**  
24 **of the Patient Protection and Affordable Care Act (P.L. 111-148), as**  
25 **amended by section 10905 of the Patient Protection and Affordable**  
26 **Care Act, and as amended by the Health Care and Education Recon-**  
27 **ciliation Act of 2010 (P.L. 111-152); and**

28 **“(b) A federal fee, tax or assessment imposed to pay for the costs**  
29 **of a federal reinsurance program.**

30 **“(2) To the extent the existing rate was approved by the Department**

1 **of Consumer and Business Services, the resulting rate, including the**  
2 **additional amount reflecting the health insurance providers fee and a**  
3 **federal fee, tax or assessment, shall be considered an approved rate.**

4 **“NOTE:** Sections 7 and 8 were deleted by amendment. Subsequent  
5 sections were not renumbered.”.

6 On page 6, lines 5 through 11, restore the bracketed material and delete  
7 the boldfaced material.

8 On page 7, line 5, delete “, who is a policyholder,”.

9 Delete lines 31 through 44 and insert:

10 **“SECTION 13.** ORS 743.417 is amended to read:

11 “743.417. (1) An individual health insurance policy shall [*contain a pro-*  
12 *vision as follows: ‘GRACE PERIOD:’*] **specify** a minimum grace period of **at**  
13 **least** 10 days after the premium due date [*will be granted*] for the payment  
14 of each premium falling due after the first premium, during which grace pe-  
15 riod the policy shall continue in force.[’ ]

16 “(2) A policy that contains a cancellation provision may add the following  
17 clause at the end of the provision [*set forth*] **described** in subsection (1) of  
18 this section: ‘subject to the right of the insurer to cancel in accordance with  
19 the cancellation provision hereof.’

20 “(3) A policy in which the insurer reserves the right to refuse renewal  
21 shall have the following clause at the beginning of the provision [*set forth*]  
22 **described** in subsection (1) of this section: ‘Unless not less than 30 days  
23 prior to the premium due date the insurer has delivered to the insured or  
24 has mailed to the last address of the insured as shown by the records of the  
25 insurer written notice of its intention not to renew this policy beyond the  
26 period for which the premium has been accepted. The insurer shall state in  
27 the notice the reason for its refusal to renew this policy.’

28 **“SECTION 13a.** ORS 743.420 is amended to read:

29 “743.420. (1) A health insurance policy, **other than a health benefit**  
30 **plan as defined in ORS 743.730**, shall contain a provision as follows:

1 'REINSTATEMENT: If any renewal premium is not paid within the grace  
2 period, a subsequent acceptance of premium by the insurer or by any insur-  
3 ance producer duly authorized by the insurer to accept such premium, with-  
4 out requiring in connection therewith an application for reinstatement, shall  
5 reinstate the policy; provided, however, that if the insurer or such insurance  
6 producer requires an application for reinstatement and issues a conditional  
7 receipt for the premium tendered, the policy will be reinstated upon approval  
8 of such application by the insurer or, lacking such approval, upon the 45th  
9 day following the date of such conditional receipt unless the insurer has  
10 previously notified the insured in writing of its disapproval of such applica-  
11 tion. The reinstated policy shall cover only loss resulting from such acci-  
12 dental injury as may be sustained after the date of reinstatement and loss  
13 due to such sickness as may begin more than 10 days after such date. In all  
14 other respects the insured and insurer shall have the same rights thereunder  
15 as they had under the policy immediately before the due date of the defaulted  
16 premium, subject to any provisions indorsed hereon or attached hereto in  
17 connection with the reinstatement. Any premium accepted in connection  
18 with a reinstatement shall be applied to a period for which premium has not  
19 been previously paid, but not to any period more than 60 days prior to the  
20 date of reinstatement.'

21 "(2) The last sentence of the provision set forth in subsection (1) of this  
22 section may be omitted from any policy which the insured has the right to  
23 continue in force subject to its terms by the timely payment of premiums  
24 until at least age 50 or, in the case of a policy issued after age 44, for at least  
25 five years from its date of issue."

26 On page 10, line 22, delete "743.549" and insert "743.552".

27 On page 11, line 23, delete "5" and insert "4".

28 After line 23, insert:

29 "**SECTION 15a.** ORS 743.552 is amended to read:

30 "743.552. The Director of the Department of Consumer and Business Ser-

1 vices shall by rule establish guidelines for the [*application of ORS 743.549,*]  
2 **coordination of benefits for individual and small group health insur-**  
3 **ance**, including:

4 “(1) The procedures by which persons insured under [*such*] **the** policies  
5 are to be made aware of the existence of [*such*] a **coordination of benefits**  
6 provision;

7 “(2) The benefits which may be subject to such a provision;

8 “(3) The effect of such a provision on the benefits provided;

9 “(4) Establishment of the order of benefit determination; and

10 “(5) Reasonable claim administration procedures to expedite claim pay-  
11 ments. [*under such a provision which shall include a time limit of 14 days*  
12 *beyond which the insurer shall not delay payment of a claim by reason of the*  
13 *application of coordination of benefits provision.*].”

14 On page 13, delete lines 12 through 45 and delete pages 14 through 16.

15 On page 17, delete lines 1 through 35 and insert:

16 **“SECTION 17.** ORS 743.730, as amended by section 49, chapter 500,  
17 Oregon Laws 2011, and section 20, chapter 38, Oregon Laws 2012, is amended  
18 to read:

19 “743.730. For purposes of ORS 743.730 to 743.773:

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

28 “(2) ‘Affiliate’ of, or person ‘affiliated’ with, a specified person means any  
29 carrier who, directly or indirectly through one or more intermediaries, con-  
30 trols or is controlled by or is under common control with a specified person.

1 For purposes of this definition, ‘control’ has the meaning given that term in  
2 ORS 732.548.

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

5 “(a) That is applied uniformly and without regard to any health status  
6 related factors to an enrollee or late enrollee [*in lieu of a preexisting condi-*  
7 *tion exclusion*];

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

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

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

15 “[~~(4)~~ ‘Basic health benefit plan’ means a health benefit plan that provides  
16 bronze plan coverage and that is approved by the Department of Consumer and  
17 Business Services under ORS 743.736.]

18 “[~~(5)~~] (4) ‘Bona fide association’ means an association that [*meets the re-*  
19 *quirements of 42 U.S.C. 300gg-91 as amended and in effect on March 23,*  
20 *2010.*]:

21 “(a) **Has been in active existence for at least five years;**

22 “(b) **Has been formed and maintained in good faith for purposes**  
23 **other than obtaining insurance;**

24 “(c) **Does not condition membership in the association on any factor**  
25 **relating to the health status of an individual or the individual’s de-**  
26 **pendent or employee;**

27 “(d) **Makes health insurance coverage that is offered through the**  
28 **association available to all members of the association regardless of**  
29 **the health status of the member or individuals who are eligible for**  
30 **coverage through the member;**

1       **“(e) Does not make health insurance coverage that is offered**  
2 **through the association available other than in connection with a**  
3 **member of the association;**

4       **“(f) Has a constitution and bylaws; and**

5       **“(g) Is not owned or controlled by a carrier, producer or affiliate**  
6 **of a carrier or producer.**

7       *“[(6) ‘Bronze plan’ means a health benefit plan that meets the criteria for*  
8 *a bronze plan prescribed by the director by rule pursuant to ORS 743.822*  
9 *(2).]*

10       *“[(7)] (5) ‘Carrier[,]’ [except as provided in ORS 743.760,] means any person*  
11 *who provides health benefit plans in this state, including:*

12       *“(a) A licensed insurance company;*

13       *“(b) A health care service contractor;*

14       *“(c) A health maintenance organization;*

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

17       *“(A) Is subject to ORS 750.301 to 750.341; or*

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

20       *“(e) Any other person or corporation responsible for the payment of ben-*  
21 *efits or provision of services.*

22       *“[(8)] (6) ‘Catastrophic plan’ means a health benefit plan that meets the*  
23 *requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is*  
24 *offered through the Oregon Health Insurance Exchange.*

25       *“[(9)] (7) ‘Creditable coverage’ means prior health care coverage as de-*  
26 *finied in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and*  
27 *includes coverage remaining in force at the time the enrollee obtains new*  
28 *coverage.*

29       *“[(10)] (8) ‘Dependent’ means the spouse or child of an eligible employee,*  
30 *subject to applicable terms of the health benefit plan covering the employee.*

1 “[(11)] (9) ‘Eligible employee’ means an employee who works on a regu-  
2 larly scheduled basis, with a normal work week of 17.5 or more hours. The  
3 employer may determine hours worked for eligibility between 17.5 and 40  
4 hours per week subject to rules of the carrier. ‘Eligible employee’ does not  
5 include employees who work on a temporary, seasonal or substitute basis.  
6 Employees who have been employed by the employer for fewer than 90 days  
7 are not eligible employees unless the employer so allows.

8 “[(12)] (10) ‘Employee’ means any individual employed by an employer.

9 “[(13)] (11) ‘Enrollee’ means an employee, dependent of the employee or  
10 an individual otherwise eligible for a group[,] **or** individual [*or portability*]  
11 health benefit plan who has enrolled for coverage under the terms of the  
12 plan.

13 “[(14)] (12) ‘Exchange’ means the health insurance exchange administered  
14 by the Oregon Health Insurance Exchange Corporation in accordance with  
15 ORS 741.310.

16 “[(15)] (13) ‘Exclusion period’ means a period during which specified  
17 treatments or services are excluded from coverage.

18 “[(16)] (14) ‘Financial impairment’ means that a carrier is not insolvent  
19 and is:

20 “(a) Considered by the director to be potentially unable to fulfill its con-  
21 tractual obligations; or

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

24 “[(17)(a)] (15)(a) ‘Geographic average rate’ means the arithmetical aver-  
25 age of the lowest premium and the corresponding highest premium to be  
26 charged by a carrier in a geographic area established by the director for the  
27 carrier’s:

28 “(A) Group health benefit plans offered to small employers; **or**

29 “(B) Individual health benefit plans[; *or*].

30 “[(C) *Portability health benefit plans.*]



1 “(b) ‘Geographic average rate’ does not include premium differences that  
2 are due to differences in benefit design, **age, tobacco use** or family compo-  
3 sition.

4 “[~~(18)~~] **(16)** ‘Grandfathered health plan’ has the meaning prescribed by the  
5 United States Secretaries of Labor, Health and Human Services and the  
6 Treasury pursuant to 42 U.S.C. 18011(e).

7 “[~~(19)~~] **(17)** ‘Group eligibility waiting period’ means, with respect to a  
8 group health benefit plan, the period of employment or membership with the  
9 group that a prospective enrollee must complete before plan coverage begins.

10 “[~~(20)(a)~~] **(18)(a)** ‘Health benefit plan’ means any:

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

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

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

19 “(b) ‘Health benefit plan’ does not include:

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

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

24 “(C) Medicare supplement insurance policies;

25 “(D) Coverage of TRICARE services pursuant to contracts with the fed-  
26 eral government;

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

1 “(F) Separately offered long term care insurance, including, but not lim-  
2 ited to, coverage of nursing home care, home health care and community-  
3 based care;

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

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

8 “(I) Dental only coverage;

9 “(J) Vision only coverage;

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

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

12 “(M) Insurance arising out of a workers’ compensation or similar law;

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

17 “(O) Any employee welfare benefit plan that is exempt from state regu-  
18 lation because of the federal Employee Retirement Income Security Act of  
19 1974, as amended.

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

24 “[21] *‘Health statement’ means any information that is intended to inform*  
25 *the carrier or insurance producer of the health status of an enrollee or pro-*  
26 *spective enrollee in a health benefit plan. ‘Health statement’ includes the*  
27 *standard health statement approved by the director under ORS 743.745.]*

28 “[22] **(19)** ‘Individual coverage waiting period’ means a period in an in-  
29 dividual health benefit plan during which no premiums may be collected and  
30 health benefit plan coverage issued is not effective.

1       “(20) **‘Individual health benefit plan’ means a health benefit plan:**  
2       **“(a) That is issued to an individual policyholder; or**  
3       **“(b) That provides individual coverage through a trust, association**  
4       **or similar group, regardless of the situs of the policy or contract.**

5       “[(23)] (21) ‘Initial enrollment period’ means a period of at least 30 days  
6 following commencement of the first eligibility period for an individual.

7       “[(24)] (22) ‘Late enrollee’ means an individual who enrolls in a group  
8 health benefit plan subsequent to the initial enrollment period during which  
9 the individual was eligible for coverage but declined to enroll. However, an  
10 eligible individual shall not be considered a late enrollee if:

11       “(a) The individual qualifies for a special enrollment period in accordance  
12 with 42 U.S.C. 300gg [*as amended and in effect on February 17, 2009*] **or as**  
13 **prescribed by rule by the Department of Consumer and Business Ser-**  
14 **vices;**

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

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

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

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

28       “[(25)] (23) ‘Minimal essential coverage’ has the meaning given that term  
29 in section 5000A(f) of the Internal Revenue Code.

30       “[(26)] (24) ‘Multiple employer welfare arrangement’ means a multiple

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

4 “[~~(27)~~] **(25)** ‘Oregon Medical Insurance Pool’ means the pool created under  
5 ORS 735.610.

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

12 “[~~(a)~~] *Pregnancy does not constitute a preexisting condition except as pro-*  
13 *vided in ORS 743.766;]*

14 “[~~(b)~~] *Genetic information does not constitute a preexisting condition in the*  
15 *absence of a diagnosis of the condition related to such information; and]*

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

19 **“(26) ‘Preexisting condition exclusion’ means:**

20 **“(a) Except for a grandfathered health plan, a limitation or exclu-**  
21 **sion of benefits or a denial of coverage based on a medical condition**  
22 **being present before the effective date of coverage or before the date**  
23 **coverage is denied, whether or not any medical advice, diagnosis, care**  
24 **or treatment was recommended or received for the condition before**  
25 **the date of coverage or denial of coverage.**

26 **“(b) With respect to a grandfathered health plan, a provision ap-**  
27 **licable to an enrollee or late enrollee that excludes coverage for ser-**  
28 **vices, charges or expenses incurred during a specified period**  
29 **immediately following enrollment for a condition for which medical**  
30 **advice, diagnosis, care or treatment was recommended or received**

1 **during a specified period immediately preceding enrollment. For pur-**  
2 **poses of this paragraph pregnancy and genetic information do not**  
3 **constitute preexisting conditions.**

4 “[~~(29)~~] **(27)** ‘Premium’ includes insurance premiums or other fees charged  
5 for a health benefit plan, including the costs of benefits paid or reimburse-  
6 ments made to or on behalf of enrollees covered by the plan.

7 “[~~(30)~~] **(28)** ‘Rating period’ means the 12-month calendar period for which  
8 premium rates established by a carrier are in effect, as determined by the  
9 carrier.

10 “[~~(31)~~] **(29)** ‘Representative’ does not include an insurance producer or an  
11 employee or authorized representative of an insurance producer or carrier.

12 “[~~(32)~~] *‘Silver plan’ means an individual or small group health benefit plan*  
13 *that meets the criteria for a silver plan prescribed by the director by rule*  
14 *pursuant to ORS 743.822 (2).*]

15 “[~~(33)(a)~~] **(30)(a)** ‘Small employer’ means an employer that employed an  
16 average of at least [~~two~~] **one** but not more than 50 employees on business  
17 days during the preceding calendar year, the majority of whom are employed  
18 within this state, and that employs at least [~~two eligible employees on the date~~  
19 ~~on which coverage takes effect under a health benefit plan offered by the em-~~  
20 ~~ployer~~] **one eligible employee on the first day of the plan year.**

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

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

28 In line 37, delete “sections 3 and 4” and insert “section 3”.

29 On page 18, delete line 1.

30 In line 2, delete “(6)” and insert “(5)”.

1 In line 4, delete “(7)” and insert “(6)”.

2 In line 5, delete “(8)” and insert “(7)”.

3 In line 6, delete “(9)” and insert “(8)”.

4 In line 29, before the period insert “and is no longer a small employer”.

5 Delete lines 30 through 45.

6 On page 19, delete lines 1 through 29 and insert:

7 **“SECTION 20.** ORS 743.734, as amended by section 13, chapter 500,  
8 Oregon Laws 2011, is amended to read:

9 “743.734. (1) Every health benefit plan shall be subject to the provisions  
10 of ORS 743.733 to 743.737, if the plan provides health benefits covering one  
11 or more employees of a small employer and if any one of the following con-  
12 ditions is met:

13 “(a) Any portion of the premium or benefits is paid by a small employer  
14 or any eligible employee is reimbursed, whether through wage adjustments  
15 or otherwise, by a small employer for any portion of the health benefit plan  
16 premium; or

17 “(b) The health benefit plan is treated by the employer or any of the eli-  
18 gible employees as part of a plan or program for the purposes of section 106,  
19 section 125 or section 162 of the Internal Revenue Code of 1986, as amended.

20 “[~~(2)~~ *Except as provided in ORS 743.733 to 743.737, 743.764 and 743A.012,*  
21 *no state law requiring the coverage or the offer of coverage of a health care*  
22 *service or benefit applies to the basic health benefit plans offered or delivered*  
23 *to a small employer.*]

24 “[~~(3)~~ **(2)** Except as otherwise provided by ORS 743.733 to 743.737 or other  
25 law, no health benefit plan offered to a small employer shall:

26 “(a) Inhibit a carrier from contracting with providers or groups of pro-  
27 viders with respect to health care services or benefits; or

28 “(b) Impose any restriction on the ability of a carrier to negotiate with  
29 providers regarding the level or method of reimbursing care or services pro-  
30 vided under health benefit plans.

1        “[4] *Except to determine the application of a preexisting condition exclu-*  
2 *sion for a late enrollee who is 19 years of age or older, a carrier shall not use*  
3 *health statements when offering small employer health benefit plans and shall*  
4 *not use any other method to determine the actual or expected health status of*  
5 *eligible enrollees. Nothing in this subsection shall prevent a carrier from using*  
6 *health statements or other information after enrollment for the purpose of*  
7 *providing services or arranging for the provision of services under a health*  
8 *benefit plan.*]

9        “[5] *Except as provided in this section and ORS 743.737, a carrier shall*  
10 *not impose different terms or conditions on the coverage, premiums or contri-*  
11 *butions of any eligible employee of a small employer that are based on the ac-*  
12 *tual or expected health status of any eligible employee.*]

13        “[6)(a)] **(3)(a)** A carrier may provide different health benefit plans to  
14 different categories of employees of a small employer [*that has at least 26 but*  
15 *no more than 50 eligible employees*] when the employer has chosen to estab-  
16 lish different categories of employees in a manner that does not relate to the  
17 actual or expected health status of such employees or their dependents. The  
18 categories must be based on bona fide employment-based classifications that  
19 are consistent with the employer’s usual business practice.

20        “(b) Except as provided in ORS 743.736 [(9)] **(8)**, a carrier that offers  
21 coverage to a small employer with no more than 25 eligible employees shall  
22 offer coverage to all eligible employees of the small employer[, *without re-*  
23 *gard to the actual or expected health status of any eligible employee*].

24        “(c) If a small employer elects to offer coverage to dependents of eligible  
25 employees, the carrier shall offer coverage to all dependents of eligible  
26 employees[, *without regard to the actual or expected health status of any eli-*  
27 *gible dependent*].

28        “[7)] **(4)** Notwithstanding any other provision of law, an insurer may not  
29 deny, delay or terminate participation of an individual in a group health  
30 benefit plan or exclude coverage otherwise provided to an individual under

1 a group health benefit plan based on a preexisting condition of the individual  
2 *[if the individual is under 19 years of age].*”.

3 In line 33, after “plans” insert a comma.

4 In line 34, before the period insert “, for which the small employer is el-  
5 ible”.

6 On page 21, line 2, delete “(3)(e)” and insert “(3)(c)”.

7 In line 5, delete “(3)(e)” and insert “(3)(c)”.

8 On page 23, delete lines 13 through 45 and delete pages 22 through 25.

9 On page 26, delete lines 1 through 14 and insert:

10 **“SECTION 22.** ORS 743.737 is amended to read:

11 *“743.737. [(1) A preexisting condition exclusion in a small employer health*  
12 *benefit plan shall apply only to a condition for which medical advice, diagno-*  
13 *sis, care or treatment was recommended or received during the six-month pe-*  
14 *riod immediately preceding the enrollment date of an enrollee or late enrollee.*  
15 *As used in this section, the enrollment date of an enrollee shall be the earlier*  
16 *of the effective date of coverage or the first day of any required group eligi-*  
17 *bility waiting period and the enrollment date of a late enrollee shall be the*  
18 *effective date of coverage.]*

19 *“[(2) A preexisting condition exclusion in a small employer health benefit*  
20 *plan shall expire as follows:]*

21 *“[(a) For an enrollee, on the earlier of the following dates:]*

22 *“[(A) Six months after the enrollee’s effective date of coverage; or]*

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

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

27 *“[(3) In applying a preexisting condition exclusion to an enrollee or late*  
28 *enrollee, except as provided in this subsection, all small employer health ben-*  
29 *efit plans shall reduce the duration of the provision by an amount equal to the*  
30 *enrollee’s or late enrollee’s aggregate periods of creditable coverage if the most*



1 *recent period of creditable coverage is ongoing or ended within 63 days after*  
2 *the enrollment date in the new small employer health benefit plan. The cred-*  
3 *iting of prior coverage in accordance with this subsection shall be applied*  
4 *without regard to the specific benefits covered during the prior period. This*  
5 *subsection does not preclude, within a small employer health benefit plan, ap-*  
6 *plication of:]*

7 **“(1) A health benefit plan issued to a small employer:**

8 **“(a) Must cover essential health benefits consistent with 42 U.S.C.**  
9 **300gg-11.**

10 **“(b) May:**

11 **“[(a)] (A) Require** an affiliation period that does not exceed two months  
12 for an enrollee or *[three months]* **90 days** for a late enrollee; or

13 **“[(b)] (B) Impose** an exclusion period for specified covered services, as  
14 established under ORS 743.745, applicable to all individuals enrolling for the  
15 first time in the small employer health benefit plan.

16 **“[(4)] (C) [A health benefit plan issued to a small employer may]** Not apply  
17 a preexisting condition exclusion to *[a person under 19 years of age]* **any**  
18 **enrollee.**

19 **“[(5)] (2)** Late enrollees in a small employer health benefit plan may be  
20 subjected to a group eligibility waiting period *[of up to 12 months or, if 19*  
21 *years of age or older, may be subjected to a preexisting condition exclusion for*  
22 *up to 12 months. If both a waiting period and a preexisting condition exclusion*  
23 *are applicable to a late enrollee, the combined period shall not exceed 12*  
24 *months]* **that does not exceed 90 days.**

25 **“[(6)] (3)** Each small employer health benefit plan shall be renewable with  
26 respect to all eligible enrollees at the option of the policyholder, small em-  
27 ployer or contract holder unless:

28 **“(a)** The policyholder, small employer or contract holder fails to pay the  
29 required premiums.

30 **“(b)** The policyholder, small employer or contract holder or, with respect

1 to coverage of individual enrollees, an enrollee or a representative of an  
2 enrollee engages in fraud or makes an intentional misrepresentation of a  
3 material fact as prohibited by the terms of the plan.

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

7 “[*(d)*] *The small employer fails to comply with the contribution requirements*  
8 *under the health benefit plan.*]

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

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

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

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

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

27 “[*(f)*] **(d)** The carrier discontinues offering and renewing a small employer  
28 health benefit plan in a specified service area within this state because of  
29 an inability to reach an agreement with the health care providers or organ-  
30 ization of health care providers to provide services under the plan within the

1 service area. In order to discontinue a plan under this paragraph, the carrier:

2 “(A) Must give notice to the department and to all policyholders covered  
3 by the plan;

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

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

11 “[*g*] (e) The carrier discontinues offering or renewing, or offering and  
12 renewing, a health benefit plan, other than a grandfathered health plan, for  
13 all small employers in this state or in a specified service area within this  
14 state, other than a plan discontinued under paragraph [*f*] (d) of this sub-  
15 section.

16 “[*h*] (f) The carrier discontinues renewing or offering and renewing a  
17 grandfathered health plan for all small employers in this state or in a spec-  
18 ified service area within this state, other than a plan discontinued under  
19 paragraph [*f*] (d) of this subsection.

20 “[*i*] (g) With respect to plans that are being discontinued under para-  
21 graph [*g* or *h*] (e) or (f) of this subsection, the carrier must:

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

25 “(B) Issue any such plans pursuant to the provisions of ORS 743.733 to  
26 743.737.

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

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

30 “[*j*] (h) The Director of the Department of Consumer and Business Ser-

1 vices orders the carrier to discontinue coverage in accordance with proce-  
2 dures specified or approved by the director upon finding that the  
3 continuation of the coverage would:

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

5 “(B) Impair the carrier’s ability to meet contractual obligations.

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

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

14 “[*7*] (4) A carrier may modify a small employer health benefit plan at  
15 the time of coverage renewal. The modification is not a discontinuation of  
16 the plan under subsection [*6*](*e*), (*g*) and (*h*) (3)(c), (e) and (f) of this sec-  
17 tion.

18 “[*8*] (5) Notwithstanding any provision of subsection [*6*] (3) of this  
19 section to the contrary, a carrier may not rescind the coverage of an enrollee  
20 in a small employer health benefit plan unless:

21 “(a) The enrollee or a person seeking coverage on behalf of the enrollee:

22 “(A) Performs an act, practice or omission that constitutes fraud; or

23 “(B) Makes an intentional misrepresentation of a material fact as pro-  
24 hibited by the terms of the plan;

25 “(b) The carrier provides at least 30 days’ advance written notice, in the  
26 form and manner prescribed by the department, to the enrollee; and

27 “(c) The carrier provides notice of the rescission to the department in the  
28 form, manner and time frame prescribed by the department by rule.

29 “[*9*] (6) Notwithstanding any provision of subsection [*6*] (3) of this  
30 section to the contrary, a carrier may not rescind a small employer health

1 benefit plan unless:

2 “(a) The small employer or a representative of the small employer:

3 “(A) Performs an act, practice or omission that constitutes fraud; or

4 “(B) Makes an intentional misrepresentation of a material fact as pro-  
5 hibited by the terms of the plan;

6 “(b) The carrier provides at least 30 days’ advance written notice, in the  
7 form and manner prescribed by the department, to each plan enrollee who  
8 would be affected by the rescission of coverage; and

9 “(c) The carrier provides notice of the rescission to the department in the  
10 form, manner and time frame prescribed by the department by rule.

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

21 “(b) **A carrier may not deny a small employer coverage under a**  
22 **health benefit plan based on participation or contribution require-**  
23 **ments, but may require small employers that do not meet partic-**  
24 **ipation or contribution requirements to enroll during the open**  
25 **enrollment period beginning November 15 and ending December 15.**

26 “[11] (8) Premium rates for small employer health benefit plans shall be  
27 subject to the following provisions:

28 “(a) Each carrier must file with the department the initial geographic  
29 average rate and any changes in the geographic average rate with respect  
30 to each health benefit plan issued by the carrier to small employers.

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

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

13 “(C) The variations in premium rates described in subparagraph (A) of  
14 this paragraph may be based **only** on one or more of the following factors  
15 **as prescribed by the department by rule**:

16 “(i) The ages of enrolled employees and their dependents, **except that the**  
17 **rate may not vary by more than 50 percent for adults;**

18 “[*ii*] *The level at which the small employer contributes to the premiums*  
19 *payable for enrolled employees and their dependents;*]

20 “[*iii*] *The level at which eligible employees participate in the health benefit*  
21 *plan;*]

22 “[*iv*] **(ii)** The level at which enrolled employees and their dependents  
23 engage in tobacco use, **except that the rate may not vary by more than**  
24 **20 percent; and**

25 “[*v*] *The level at which enrolled employees and their dependents engage in*  
26 *health promotion, disease prevention or wellness programs;*]

27 “[*vi*] *The period of time during which a small employer retains uninter-*  
28 *rupted coverage in force with the same carrier; and]*

29 “[*vii*] **(iii)** Adjustments to reflect [*the provision of benefits not required*  
30 *to be covered by the basic health benefit plan and]* differences in family com-

1 position.

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

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

11 “[*(E)*] **(D)** A carrier shall apply the carrier’s schedule of premium rate  
12 variations as approved by the department and in accordance with this para-  
13 graph. Except as otherwise provided in this section, the premium rate es-  
14 tablished by a carrier for a small employer health benefit plan shall apply  
15 uniformly to all employees of the small employer enrolled in that plan.

16 “(c) Except as provided in paragraph (b) of this subsection, the variation  
17 in premium rates between different health benefit plans offered by a carrier  
18 to small employers must be based solely on objective differences in plan de-  
19 sign or coverage, **age, tobacco use and family composition** and must not  
20 include differences based on the risk characteristics of groups assumed to  
21 select a particular health benefit plan.

22 “(d) A carrier may not increase the rates of a health benefit plan issued  
23 to a small employer more than once in a 12-month period. Annual rate in-  
24 creases shall be effective on the plan anniversary date of the health benefit  
25 plan issued to a small employer. The percentage increase in the premium rate  
26 charged to a small employer for a new rating period may not exceed the sum  
27 of the following:

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

30 “(B) Any adjustment attributable to changes in age[, *except an additional*

1 *adjustment may be made to reflect the provision of benefits not required to be*  
2 *covered by the basic health benefit plan]* and differences in family composi-  
3 tion.

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

6 “[~~(12)~~] **(9)** In connection with the offering for sale of any health benefit  
7 plan to a small employer, each carrier shall make a reasonable disclosure  
8 as part of its solicitation and sales materials of:

9 “(a) The full array of health benefit plans that are offered to small em-  
10 ployers by the carrier;

11 “(b) The authority of the carrier to adjust rates **and premiums**, and the  
12 extent to which the carrier will consider age, **tobacco use**, family composi-  
13 tion and geographic factors in establishing and adjusting rates[;] **and pre-**  
14 **miums; and**

15 “**(c) The benefits and premiums for all health insurance coverage**  
16 **for which the employer is qualified.**

17 “[~~(c)~~ *Provisions relating to renewability of policies and contracts; and]*

18 “[~~(d)~~ *Provisions affecting any preexisting condition exclusion.*]

19 “[~~(13)(a)~~] **(10)(a)** Each carrier shall maintain at its principal place of  
20 business a complete and detailed description of its rating practices and re-  
21 newal underwriting practices relating to its small employer health benefit  
22 plans, including information and documentation that demonstrate that its  
23 rating methods and practices are based upon commonly accepted actuarial  
24 practices and are in accordance with sound actuarial principles.

25 “(b) A carrier offering a small employer health benefit plan shall file with  
26 the department at least once every 12 months an actuarial certification that  
27 the carrier is in compliance with ORS 743.733 to 743.737 and that the rating  
28 methods of the carrier are actuarially sound. Each certification shall be in  
29 a uniform form and manner and shall contain such information as specified  
30 by the department. A copy of each certification shall be retained by the



1 carrier at its principal place of business. **A carrier is not required to file**  
2 **the actuarial certification under this paragraph if the department has**  
3 **approved the carrier's rate filing within the preceding 12-month pe-**  
4 **riod.**

5 “(c) A carrier shall make the information and documentation described  
6 in paragraph (a) of this subsection available to the department upon request.  
7 Except as provided in ORS 743.018 and except in cases of violations of ORS  
8 743.733 to 743.737, the information shall be considered proprietary and trade  
9 secret information and shall not be subject to disclosure to persons outside  
10 the department except as agreed to by the carrier or as ordered by a court  
11 of competent jurisdiction.

12 “[~~(14)~~] **(11)** A carrier shall not provide any financial or other incentive  
13 to any insurance producer that would encourage the insurance producer to  
14 market and sell health benefit plans of the carrier to small employer groups  
15 based on a small employer group's anticipated claims experience.

16 “[~~(15)~~] **(12)** For purposes of this section, the date a small employer health  
17 benefit plan is continued shall be the anniversary date of the first issuance  
18 of the health benefit plan.

19 “[~~(16)~~] **(13)** A carrier must include a provision that offers coverage to all  
20 eligible employees of a small employer and to all dependents of the eligible  
21 employees to the extent the employer chooses to offer coverage to depen-  
22 dents.

23 “[~~(17)~~] **(14)** All small employer health benefit plans shall contain special  
24 enrollment periods during which eligible employees and dependents may en-  
25 roll for coverage, as provided [*in 42 U.S.C. 300gg as amended and in effect*  
26 *on February 17, 2009*] **by federal law and rules adopted by the depart-**  
27 **ment.**

28 “[~~(18)~~] **(15)** A small employer health benefit plan may not impose annual  
29 or lifetime limits on the dollar amount of [*the*] essential health benefits  
30 [*prescribed by the United States Secretary of Health and Human Services*

1 *pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law].*

2 “[~~(19)~~] (16) This section does not require a carrier to actively market, of-  
3 fer, issue or accept applications for a grandfathered health plan or from a  
4 small employer not eligible for coverage under such a plan [*as provided by*  
5 *the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by*  
6 *the Health Care and Education Reconciliation Act (P.L. 111-152)].”.*

7 On page 28, delete lines 11 through 14 and insert:

8 “(1) Except for an individual grandfathered health plan, a carrier may  
9 require an individual applying for coverage under an individual or small  
10 group health benefit plan to respond to health-related questions only for the  
11 purpose of managing the individual’s health care and may not use the in-  
12 formation to deny coverage.

13 “(2) Except for an individual grandfathered health plan, if a carrier re-  
14 quires an individual to respond to health-related questions, the carrier must  
15 also notify the individual, in the form and manner prescribed by the De-  
16 partment of Consumer and Business Services, that the responses may not be  
17 used to deny coverage.”.

18 On page 32, delete lines 2 through 45 and delete page 33.

19 On page 34, delete lines 1 through 34 and insert:

20 “**SECTION 28.** ORS 743.766, as amended by section 4, chapter 24, Oregon  
21 Laws 2012, is amended to read:

22 “743.766. [(1) *All carriers that offer an individual health benefit plan and*  
23 *evaluate the health status of individuals for purposes of eligibility shall use*  
24 *the standard health statement established under ORS 743.745 and may not use*  
25 *any other method to determine the health status of an individual. Nothing in*  
26 *this subsection shall prevent a carrier from using health information after en-*  
27 *rollment for the purpose of providing services or arranging for the provision*  
28 *of services under a health benefit plan.]*

29 “[~~(2)(a)~~] *If an individual is accepted for coverage under an individual health*  
30 *benefit plan, the carrier shall not impose exclusions or limitations other*

1 *than:]*

2 *“(A) A preexisting condition exclusion that complies with the following*  
3 *requirements:]*

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

8 *“(ii) The exclusion expires no later than six months after the individual’s*  
9 *effective date of coverage; and]*

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

12 *“(B) An individual coverage waiting period of 90 days; or]*

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

15 *“(b) Except for grandfathered health plans, pregnancy of individuals who*  
16 *are under 19 years of age may not constitute a preexisting condition for pur-*  
17 *poses of this section.]*

18 **“(1) With respect to coverage under an individual health benefit**  
19 **plan, a carrier:**

20 **“(a) May not impose an individual coverage waiting period that ex-**  
21 **ceeds 90 days.**

22 **“(b) May impose an exclusion period for specified covered services**  
23 **applicable to all individuals enrolling for the first time in the individ-**  
24 **ual health benefit plan.**

25 **“(c) With respect to individual coverage under a grandfathered**  
26 **health plan, a carrier may not impose a preexisting condition exclu-**  
27 **sion unless the exclusion complies with the following requirements:**

28 **“(A) The exclusion applies only to a condition for which medical**  
29 **advice, diagnosis, care or treatment was recommended or received**  
30 **during the six-month period immediately preceding the individual’s**

1 **effective date of coverage.**

2 **“(B) The exclusion expires no later than six months after the**  
3 **individual’s effective date of coverage.**

4 “[3] (2) If the carrier elects to restrict coverage [*through the application*  
5 *of a preexisting condition exclusion or an individual coverage waiting period*  
6 *provision*] **as described in subsection (1) of this section**, the carrier shall  
7 reduce the duration of the [*provision*] **period during which the restriction**  
8 **is imposed** by an amount equal to the individual’s aggregate periods of  
9 creditable coverage if the most recent period of creditable coverage is ongo-  
10 ing or ended within 63 days after the effective date of coverage in the new  
11 individual health benefit plan. The crediting of prior coverage in accordance  
12 with this subsection shall be applied without regard to the specific benefits  
13 covered during the prior period.

14 “[4] *If an eligible prospective enrollee is rejected for coverage under an*  
15 *individual health benefit plan, the prospective enrollee shall be eligible to ap-*  
16 *ply for coverage under the Oregon Medical Insurance Pool.*]

17 **“(3) An individual health benefit plan other than a grandfathered**  
18 **health plan must cover, at a minimum, all essential health benefits.**

19 “[5] (4) [*If a carrier accepts an individual for coverage under*] **A carrier**  
20 **shall renew** an individual health benefit plan, **including a health benefit**  
21 **plan issued through a bona fide association**, [*the carrier shall renew the*  
22 *policy*] unless:

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

24 “(b) The policyholder or a representative of the policyholder engages in  
25 fraud or makes an intentional misrepresentation of a material fact as pro-  
26 hibited by the terms of the policy.

27 “(c) The carrier discontinues offering or renewing, or offering and re-  
28 newing, all of its individual health benefit plans in this state or in a speci-  
29 fied service area within this state. In order to discontinue the plans under  
30 this paragraph, the carrier:

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

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

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

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

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

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

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

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

28       “(e) The carrier discontinues offering or renewing, or offering and re-  
29 newing, an individual health benefit plan, other than a grandfathered health  
30 plan, for all individuals in this state or in a specified service area within this

1 state, other than a plan discontinued under paragraph (d) of this subsection.

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

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

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

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

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

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

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

19 “(B) Impair the carrier’s ability to meet its contractual obligations.

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

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

29 “[6] (5) A carrier may modify an individual health benefit plan at the  
30 time of coverage renewal. The modification is not a discontinuation of the

1 plan under subsection [(5)(c)] **(4)(c)**, (e) and (f) of this section.

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

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

7 “(b) Makes an intentional misrepresentation of a material fact as pro-  
8 hibited by the terms of the policy.

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

12 “[~~(9)~~] **(7)** A carrier that continues to offer coverage in the individual  
13 market in this state is not required to offer coverage in all of the carrier’s  
14 individual health benefit plans. However, if a carrier elects to continue a  
15 plan that is closed to new individual policyholders instead of offering alter-  
16 native coverage in its other individual health benefit plans, the coverage for  
17 all existing policyholders in the closed plan is renewable in accordance with  
18 subsection [(5)] **(4)** of this section.

19 “[~~(10)~~] **(8)** An individual health benefit plan may not impose annual or  
20 lifetime limits on the dollar amount of [~~the~~] essential health benefits [*pre-*  
21 *scribed by the United States Secretary of Health and Human Services pursuant*  
22 *to 42 U.S.C. 300gg-11, except as permitted by federal law*].

23 “[~~(11)~~] **(9)** This section does not require a carrier to actively market, offer,  
24 issue or accept applications for a grandfathered health plan or from an in-  
25 dividual not eligible for coverage under such a plan [*as provided by the Pa-*  
26 *tient Protection and Affordable Care Act (P.L. 111-148) as amended by the*  
27 *Health Care and Education Reconciliation Act (P.L. 111-152)*].”.

28 In line 45, delete “ac-”.

29 On page 35, delete the boldfaced material.

30 In line 22, before the semicolon insert “or student health plans”.

1 On page 36, delete lines 27 through 45 and delete page 37.

2 On page 38, delete lines 1 through 36 and insert:

3 **“SECTION 31.** ORS 743.822, as amended by section 8, chapter 24, Oregon  
4 Laws 2012, and section 21, chapter 38, Oregon Laws 2012, is amended to read:

5 “743.822. (1) In each individual or small group market, in which a carrier  
6 offers a health benefit plan through [*the exchange*] or outside of the **Oregon**  
7 **Health Insurance** Exchange, [*a*] **the** carrier must offer to residents of this  
8 state [*bronze and silver plans*] **a bronze and a silver plan** approved by the  
9 Department of Consumer and Business Services as meeting the requirements  
10 of subsection (2) of this section.

11 “(2) The [*Director of the Department of Consumer and Business Services*]  
12 **department** shall prescribe by rule the[:]

13 “[*a*] *Requirements for a bronze plan to ensure that a bronze plan offered*  
14 *in this state is actuarially equivalent to 60 percent of the full actuarial value*  
15 *of benefits included in the essential health benefits package prescribed by the*  
16 *United States Secretary of Health and Human Services under 42 U.S.C.*  
17 *18022(a).*]

18 “[*b*] *Requirements for a silver plan to ensure that a silver plan offered in*  
19 *this state is actuarially equivalent to 70 percent of the full actuarial value of*  
20 *benefits included in the essential health benefits package prescribed by the*  
21 *United States Secretary of Health and Human Services under 42 U.S.C.*  
22 *18022(a).*]

23 “[*c*] form, level of coverage and benefit design for the bronze and silver  
24 plans [*to be used by carriers in the individual and small group market in this*  
25 *state.*] **that must be offered under subsection (1) of this section.**

26 “(3) As used in this section, ‘health benefit plan’ has the meaning given  
27 that term in ORS 743.730.

28 **“SECTION 32.** ORS 743.894 is amended to read:

29 “743.894. (1) As used in this section, ‘rescind’ means to retroactively can-  
30 cel or discontinue coverage under a health benefit plan or group or individ-



1 ual health insurance policy for reasons other than failure to timely pay  
2 required premiums or required contributions toward the cost of coverage.

3 “(2) An insurer may not rescind coverage of an individual under a health  
4 benefit plan or group or individual health insurance policy unless:

5 “(a) The individual or a person seeking coverage on behalf of the indi-  
6 vidual:

7 “(A) Performs an act, practice or omission that constitutes fraud; or

8 “(B) Makes an intentional misrepresentation of a material fact as pro-  
9 hibited by the terms of the plan or policy; and

10 “(b) The insurer provides at least 30 days’ advance written notice, in the  
11 form and manner prescribed by the Department of Consumer and Business  
12 Services, to the individual.

13 “(3) An insurer may not rescind coverage of a group under a health ben-  
14 efit plan unless:

15 “(a) The plan sponsor:

16 “(A) Performs an act, practice or omission that constitutes fraud; or

17 “(B) Makes an intentional misrepresentation of a material fact as pro-  
18 hibited by the terms of the plan; and

19 “(b) The insurer provides at least 30 days’ advance written notice, in the  
20 form and manner prescribed by the department, to each plan enrollee or  
21 policy holder who would be affected by the rescission of coverage.

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

25 **“(5) This section does not apply to long term care insurance that**  
26 **is subject to ORS 743.650 to 743.665.”.**

27 On page 39, line 22, delete “special” and insert “additional”.

28 In line 28, delete “within the”.

29 In line 29, delete “scope of” and insert “consistent with the”.

30 On page 40, after line 20, insert:

1 “(6) This section is exempt from ORS 743A.001.”.

2 On page 41, after line 37, insert:

3 **“SECTION 35a.** ORS 746.045 is amended to read:

4 “746.045. (1) No person shall personally or otherwise offer, promise, allow,  
5 give, set off, pay or receive, directly or indirectly, any rebate of or rebate  
6 of part of the premium payable on an insurance policy or the insurance  
7 producer’s commission thereon, or earnings, profit, dividends or other benefit  
8 founded, arising, accruing or to accrue on or from the policy, or any other  
9 valuable consideration or inducement to or for insurance on any domestic  
10 risk, which is not specified in the policy.

11 **“(2) A premium discount or rebate is not prohibited by this section  
12 if the discount or rebate is:**

13 **“(a) Offered in connection with a program of health promotion or  
14 disease prevention, as described in 42 U.S.C. 300gg-4;**

15 **“(b) Paid for participation in a program to promote healthy behav-  
16 iors under ORS 743.824; or**

17 **“(c) Offered in connection with a wellness program defined by the  
18 Department of Consumer and Business Services by rule.”.**

19 On page 44, after line 37, insert:

20 **“SECTION 37a. (1) A carrier may not provide coverage under a  
21 portability health benefit plan in this state after December 31, 2013.**

22 **“(2) A carrier discontinuing a portability health benefit plan in ac-  
23 cordance with this section must comply with the requirements of ORS  
24 743.737 (3)(e), 743.766 (4)(c) and 743.769.”.**

25 In line 39, delete “82” and insert “64”.

26 In line 41, delete “82” and insert “64”.

27 On page 46, line 6, delete “83” and insert “65”.

28 In line 29, delete “82” and insert “64”.

29 On page 54, line 38, delete “shall” and insert “may”.

30 On page 58, delete lines 33 through 45 and delete pages 59 through 87.

1 On page 88, delete lines 1 through 41.

2 After line 44, insert:

3 **“SECTION 54.** ORS 731.036 is amended to read:

4 “731.036. Except as provided in ORS 743.061 or as specifically provided  
5 by law, the Insurance Code does not apply to any of the following to the  
6 extent of the subject matter of the exemption:

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

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

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

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

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

20 “(6) Cities, counties, school districts, community college districts, com-  
21 munity college service districts or districts, as defined in ORS 198.010 and  
22 198.180, that either individually or jointly insure for health insurance cov-  
23 erage, excluding disability insurance, their employees or retired employees,  
24 or their dependents, or students engaged in school activities, or combination  
25 of employees and dependents, with or without employee or student contribu-  
26 tions, if all of the following conditions are met:

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

29 “(A) In the case of a school district, community college district or com-  
30 munity college service district, the number of covered employees and depen-

1 dents and retired employees and dependents aggregates at least 500  
2 individuals;

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

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

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

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

15 “(d) Enrollees must be provided copies of summary plan descriptions in-  
16 cluding:

17 “(A) Written general information about services provided, access to ser-  
18 vices, charges and scheduling applicable to each enrollee’s coverage;

19 “(B) The program’s grievance and appeal process; and

20 “(C) Other group health plan enrollee rights, disclosure or written pro-  
21 cedure requirements established under ORS chapters 743 and 743A;

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

24 “(A) Program contributions and reserves must be held in separate ac-  
25 counts and used for the exclusive benefit of the program;

26 “(B) The program must maintain adequate reserves. Reserves may be in-  
27 vested in accordance with the provisions of ORS chapter 293. Reserve ade-  
28 quacy must be calculated annually with proper actuarial calculations  
29 including the following:

30 “(i) Known claims, paid and outstanding;

1       “(ii) A history of incurred but not reported claims;  
2       “(iii) Claims handling expenses;  
3       “(iv) Unearned contributions; and  
4       “(v) A claims trend factor; and  
5       “(C) The program must maintain adequate reinsurance against the risk  
6 of economic loss in accordance with the provisions of ORS 742.065 unless the  
7 program has received written approval for an alternative arrangement for  
8 protection against economic loss from the Director of the Department of  
9 Consumer and Business Services;  
10       “(f) The individual or jointly self-insured program must have sufficient  
11 personnel to service the employee benefit program or must contract with a  
12 third party administrator licensed under ORS chapter 744 as a third party  
13 administrator to provide such services;  
14       “(g) The individual or jointly self-insured program shall be subject to as-  
15 sessment in accordance with ORS 735.614 [*and former enrollees shall be eli-*  
16 *gible for portability coverage in accordance with ORS 735.616*];  
17       “(h) The public body, or the program administrator in the case of a joint  
18 insurance program of two or more public bodies, files with the Director of  
19 the Department of Consumer and Business Services copies of all documents  
20 creating and governing the program, all forms used to communicate the  
21 coverage to beneficiaries, the schedule of payments established to support the  
22 program and, annually, a financial report showing the total incurred cost of  
23 the program for the preceding year. A copy of the annual audit required by  
24 ORS 297.425 may be used to satisfy the financial report filing requirement;  
25 and  
26       “(i) Each public body in a joint insurance program is liable only to its  
27 own employees and no others for benefits under the program in the event,  
28 and to the extent, that no further funds, including funds from insurance  
29 policies obtained by the pool, are available in the joint insurance pool.  
30       “(7) All ambulance services.

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

5 “(a) Towing service.

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

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

14 “(9)(a) A person described in this subsection who, in an agreement to  
15 lease or to finance the purchase of a motor vehicle, agrees to waive for no  
16 additional charge the amount specified in paragraph (b) of this subsection  
17 upon total loss of the motor vehicle because of physical damage, theft or  
18 other occurrence, as specified in the agreement. The exemption established  
19 in this subsection applies to the following persons:

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

22 “(B) The lessor of the motor vehicle.

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

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

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

29 “(10) A self-insurance program for tort liability or property damage that  
30 is established by two or more affordable housing entities and that complies

1 with the same requirements that public bodies must meet under ORS 30.282  
2 (6). As used in this subsection:

3 “(a) ‘Affordable housing’ means housing projects in which some of the  
4 dwelling units may be purchased or rented, with or without government as-  
5 sistance, on a basis that is affordable to individuals of low income.

6 “(b) ‘Affordable housing entity’ means any of the following:

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

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

13 “(C) A partnership or limited liability company that is engaged in pro-  
14 viding affordable housing and that is affiliated with a housing authority de-  
15 scribed in subparagraph (A) of this paragraph or a nonprofit corporation  
16 described in subparagraph (B) of this paragraph if the housing authority or  
17 nonprofit corporation:

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

20 “(ii) Has the power to direct the management or policies of the partner-  
21 ship or limited liability company;

22 “(iii) Has entered into a contract to lease, manage or operate the afford-  
23 able housing owned by the partnership or limited liability company; or

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

26 “(11) A community-based health care initiative approved by the Adminis-  
27 trator of the Office for Oregon Health Policy and Research under ORS  
28 735.723 operating a community-based health care improvement program ap-  
29 proved by the administrator.

30 “(12) Except as provided in ORS 735.500 and 735.510, a person certified

1 by the Department of Consumer and Business Services to operate a retainer  
2 medical practice.

3 **“SECTION 55.** ORS 735.625 is amended to read:

4 “735.625. (1) Except as provided in subsection (3)(c) of this section, the  
5 Oregon Medical Insurance Pool Board shall offer major medical expense  
6 coverage to every eligible person.

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

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

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

26 “(c) The board may provide a separate Medicare supplement policy for  
27 individuals under the age of 65 who are receiving Medicare disability bene-  
28 fits. The board shall adopt rules to establish benefits, deductibles,  
29 coinsurance, exclusions and limitations, premiums and eligibility require-  
30 ments for the Medicare supplement policy.



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

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

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

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

23 “(d) The board shall annually determine adjusted benefits and premiums.  
24 The adjustments shall be in keeping with the purposes of ORS 735.600 to  
25 735.650, subject to a limitation of keeping pool losses under one percent of  
26 the total of all medical insurance premiums, subscriber contract charges and  
27 110 percent of all benefits paid by member self-insurance arrangements. The  
28 board may determine the total number of persons that may be enrolled for  
29 coverage at any time and may permit and prohibit enrollment in order to  
30 maintain the number authorized. Nothing in this paragraph authorizes the

1 board to prohibit enrollment for any reason other than to control the number  
2 of persons in the pool.

3 “(5)(a) The board may apply:

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

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

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

19 “(c) The board may adopt rules applying a preexisting conditions pro-  
20 vision to a person who is eligible for coverage under ORS 735.615 (1)(d).

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

27 “(6)(a) Benefits otherwise payable under pool coverage shall be reduced  
28 by all amounts paid or payable through any other health insurance, or self-  
29 insurance arrangement, and by all hospital and medical expense benefits paid  
30 or payable under any workers’ compensation coverage, automobile medical

1 payment or liability insurance whether provided on the basis of fault or  
2 nonfault, and by any hospital or medical benefits paid or payable under or  
3 provided pursuant to any state or federal law or program except the  
4 Medicaid portion of the medical assistance program offering a level of health  
5 services described in ORS 414.707.

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

10 “(7) [*Except as provided in ORS 735.616,*] No mandated benefit statutes  
11 apply to pool coverage under ORS 735.600 to 735.650.

12 “(8) Pool coverage may be furnished through a health care service con-  
13 tractor or such alternative delivery system as will contain costs while  
14 maintaining quality of care.”

15 In line 45, delete “75” and insert “56”.

16 On page 89, line 23, delete “76” and insert “57”.

17 In line 39, delete “77” and insert “58”.

18 On page 90, delete lines 24 through 45 and delete pages 91 through 93.

19 On page 94, delete lines 1 through 17 and insert:

20 “**SECTION 59.** ORS 743.730, as amended by section 49, chapter 500,  
21 Oregon Laws 2011, section 20, chapter 38, Oregon Laws 2012, and section 17  
22 of this 2013 Act, is amended to read:

23 “743.730. For purposes of ORS 743.730 to 743.773:

24 “(1) ‘Actuarial certification’ means a written statement by a member of  
25 the American Academy of Actuaries or other individual acceptable to the  
26 Director of the Department of Consumer and Business Services that a carrier  
27 is in compliance with the provisions of ORS 743.736 based upon the person’s  
28 examination, including a review of the appropriate records and of the  
29 actuarial assumptions and methods used by the carrier in establishing pre-  
30 mium rates for small employer health benefit plans.

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

6       “(3) ‘Affiliation period’ means, under the terms of a group health benefit  
7 plan issued by a health care service contractor, a period:

8       “(a) That is applied uniformly and without regard to any health status  
9 related factors to an enrollee or late enrollee;

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

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

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

17       “(4) ‘Bona fide association’ means an association that:

18       “(a) Has been in active existence for at least five years;

19       “(b) Has been formed and maintained in good faith for purposes other  
20 than obtaining insurance;

21       “(c) Does not condition membership in the association on any factor re-  
22 lating to the health status of an individual or the individual’s dependent or  
23 employee;

24       “(d) Makes health insurance coverage that is offered through the associ-  
25 ation available to all members of the association regardless of the health  
26 status of the member or individuals who are eligible for coverage through  
27 the member;

28       “(e) Does not make health insurance coverage that is offered through the  
29 association available other than in connection with a member of the associ-  
30 ation;

1 “(f) Has a constitution and bylaws; and

2 “(g) Is not owned or controlled by a carrier, producer or affiliate of a  
3 carrier or producer.

4 “(5) ‘Carrier’ means any person who provides health benefit plans in this  
5 state, including:

6 “(a) A licensed insurance company;

7 “(b) A health care service contractor;

8 “(c) A health maintenance organization;

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

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

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

14 “(e) Any other person or corporation responsible for the payment of ben-  
15 efits or provision of services.

16 “(6) ‘Catastrophic plan’ means a health benefit plan that meets the re-  
17 quirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is of-  
18 ferred through the Oregon Health Insurance Exchange.

19 “(7) ‘Creditable coverage’ means prior health care coverage as defined in  
20 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes  
21 coverage remaining in force at the time the enrollee obtains new coverage.

22 “(8) ‘Dependent’ means the spouse or child of an eligible employee, subject  
23 to applicable terms of the health benefit plan covering the employee.

24 “(9) ‘Eligible employee’ means an employee who works on a regularly  
25 scheduled basis, with a normal work week of 17.5 or more hours. The em-  
26 ployer may determine hours worked for eligibility between 17.5 and 40 hours  
27 per week subject to rules of the carrier. ‘Eligible employee’ does not include  
28 employees who work on a temporary, seasonal or substitute basis. Employees  
29 who have been employed by the employer for fewer than 90 days are not el-  
30 igible employees unless the employer so allows.

1 “(10) ‘Employee’ means any individual employed by an employer.

2 “(11) ‘Enrollee’ means an employee, dependent of the employee or an in-  
3 dividual otherwise eligible for a group or individual health benefit plan who  
4 has enrolled for coverage under the terms of the plan.

5 “(12) ‘Exchange’ means the health insurance exchange administered by  
6 the Oregon Health Insurance Exchange Corporation in accordance with ORS  
7 741.310.

8 “(13) ‘Exclusion period’ means a period during which specified treatments  
9 or services are excluded from coverage.

10 “(14) ‘Financial impairment’ means that a carrier is not insolvent and is:

11 “(a) Considered by the director to be potentially unable to fulfill its con-  
12 tractual obligations; or

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

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

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

19 “(B) Individual health benefit plans.

20 “(b) ‘Geographic average rate’ does not include premium differences that  
21 are due to differences in benefit design, age, tobacco use or family composi-  
22 tion.

23 “(16) ‘Grandfathered health plan’ has the meaning prescribed by the  
24 United States Secretaries of Labor, Health and Human Services and the  
25 Treasury pursuant to 42 U.S.C. 18011(e).

26 “(17) ‘Group eligibility waiting period’ means, with respect to a group  
27 health benefit plan, the period of employment or membership with the group  
28 that a prospective enrollee must complete before plan coverage begins.

29 “(18)(a) ‘Health benefit plan’ means any:

30 “(A) Hospital expense, medical expense or hospital or medical expense

1 policy or certificate;

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

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

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

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

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

13 “(C) Medicare supplement insurance policies;

14 “(D) Coverage of TRICARE services pursuant to contracts with the fed-  
15 eral government;

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

20 “(F) Separately offered long term care insurance, including, but not lim-  
21 ited to, coverage of nursing home care, home health care and community-  
22 based care;

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

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

27 “(I) Dental only coverage;

28 “(J) Vision only coverage;

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

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

1 “(M) Insurance arising out of a workers’ compensation or similar law;

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

6 “(O) Any employee welfare benefit plan that is exempt from state regu-  
7 lation because of the federal Employee Retirement Income Security Act of  
8 1974, as amended.

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

13 “(19) ‘Individual coverage waiting period’ means a period in an individual  
14 health benefit plan during which no premiums may be collected and health  
15 benefit plan coverage issued is not effective.

16 “(20) ‘Individual health benefit plan’ means a health benefit plan:

17 “(a) That is issued to an individual policyholder; or

18 “(b) That provides individual coverage through a trust, association or  
19 similar group, regardless of the situs of the policy or contract.

20 “(21) ‘Initial enrollment period’ means a period of at least 30 days fol-  
21 lowing commencement of the first eligibility period for an individual.

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

26 “(a) The individual qualifies for a special enrollment period in accordance  
27 with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer  
28 and Business Services;

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

30 “(c) A court issues an order that coverage be provided for a spouse or



1 minor child under an employee’s employer sponsored health benefit plan and  
2 request for enrollment is made within 30 days after issuance of the court  
3 order;

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

7 “(e) The individual’s coverage under Medicaid, Medicare, TRICARE, In-  
8 dian Health Service or a publicly sponsored or subsidized health plan, in-  
9 cluding, but not limited to, the medical assistance program under ORS  
10 chapter 414, has been involuntarily terminated within 63 days after applying  
11 for coverage in a group health benefit plan.

12 “(23) ‘Minimal essential coverage’ has the meaning given that term in  
13 section 5000A(f) of the Internal Revenue Code.

14 “(24) ‘Multiple employer welfare arrangement’ means a multiple employer  
15 welfare arrangement as defined in section 3 of the federal Employee Retire-  
16 ment Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject  
17 to ORS 750.301 to 750.341.

18 “(25) ‘Oregon Medical Insurance Pool’ means the pool created under ORS  
19 735.610.

20 “(26) ‘Preexisting condition exclusion’ means:

21 “(a) Except for a grandfathered health plan, a limitation or exclusion of  
22 benefits or a denial of coverage based on a medical condition being present  
23 before the effective date of coverage or before the date coverage is denied,  
24 whether or not any medical advice, diagnosis, care or treatment was recom-  
25 mended or received for the condition before the date of coverage or denial  
26 of coverage.

27 “(b) With respect to a grandfathered health plan, a provision applicable  
28 to an enrollee or late enrollee that excludes coverage for services, charges  
29 or expenses incurred during a specified period immediately following enroll-  
30 ment for a condition for which medical advice, diagnosis, care or treatment

1 was recommended or received during a specified period immediately preced-  
2 ing enrollment. For purposes of this paragraph pregnancy and genetic infor-  
3 mation do not constitute preexisting conditions.

4 “(27) ‘Premium’ includes insurance premiums or other fees charged for a  
5 health benefit plan, including the costs of benefits paid or reimbursements  
6 made to or on behalf of enrollees covered by the plan.

7 “(28) ‘Rating period’ means the 12-month calendar period for which pre-  
8 mium rates established by a carrier are in effect, as determined by the car-  
9 rier.

10 “(29) ‘Representative’ does not include an insurance producer or an em-  
11 ployee or authorized representative of an insurance producer or carrier.

12 “(30)(a) ‘Small employer’ means an employer that employed an average of  
13 at least one but not more than [50] **100** employees on business days during  
14 the preceding calendar year, the majority of whom are employed within this  
15 state, and that employs at least one eligible employee on the first day of the  
16 plan year.

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

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

24 In line 18, delete “79” and insert “60”.

25 On page 95, after line 3, insert:

26 “**SECTION 61.** ORS 743.769 is amended to read:

27 “743.769. (1) Each carrier shall actively market all individual health ben-  
28 efit plans sold by the carrier **that are not grandfathered health plans.**

29 “(2) Except as provided in subsection (3) of this section, no carrier or  
30 insurance producer shall, directly or indirectly, discourage an individual

1 from filing an application for coverage because of the health status, claims  
2 experience, occupation or geographic location of the individual.

3 “(3) Subsection (2) of this section does not apply with respect to infor-  
4 mation provided by a carrier to an individual regarding the established ge-  
5 ographic service area or a restricted network provision of a carrier.

6 “(4) Rejection by a carrier of an application for coverage shall be in  
7 writing and shall state the reason or reasons for the rejection.

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

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

23 In line 4, delete “80” and insert “62”.

24 On page 97, line 37, delete “81” and insert “63”.

25 Delete lines 43 through 45 and delete page 98 and insert:

26 **“SECTION 64. Sections 2 to 6 and 40 of this 2013 Act and the**  
27 **amendments to ORS 192.556, 410.080, 413.011, 413.032, 413.201, 414.041,**  
28 **414.231, 414.826, 414.828, 414.839, 433.443, 731.036, 735.625, 741.300, 743.018,**  
29 **743.019, 743.405, 743.417, 743.420, 743.522, 743.524, 743.526, 743.528, 743.550,**  
30 **743.552, 743.560, 743.610, 743.731, 743.733, 743.736, 743.737, 743.745, 743.748,**

1 743.751, 743.752, 743.754, 743.757, 743.766, 743.767, 743.769, 743.777, 743.804,  
2 743.894, 743A.090, 743A.192, 746.015 and 746.045 and section 1, chapter 867,  
3 Oregon Laws 2009, by sections 10 to 16, 18, 19, 21 to 30, 32 to 37, 42 to  
4 58, 60 and 61 of this 2013 Act become operative January 1, 2014.

5 **“SECTION 65.** ORS 414.831, 414.841, 414.842, 414.844, 414.846, 414.848,  
6 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866,  
7 414.868, 414.870, 414.872, 735.616, 735.700, 735.701, 735.702, 735.703, 735.705,  
8 735.707, 735.709, 735.710, 735.712, 743.549, 743.760 and 743.761 are repealed  
9 January 1, 2014.

10 **“SECTION 66.** (1)(a) The amendments to ORS 743.730 by section 17  
11 of this 2013 Act become operative January 2, 2014.

12 **“(b)** The amendments to ORS 743.730 by section 59 of this 2013 Act  
13 become operative January 2, 2016.

14 **“(2)** The amendments to ORS 731.146, 743.734 and 743.822 by sections  
15 9, 20 and 31 of this 2013 Act become operative January 2, 2014.

16 **“SECTION 67.** This 2013 Act being necessary for the immediate  
17 preservation of the public peace, health and safety, an emergency is  
18 declared to exist, and this 2013 Act takes effect on its passage.”.

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