Senate Bill 1565

Sponsored by Senator BAERTSCHIGER JR; Senators BOQUIST, CLOSE, FERRIOLI, HANSELL, JOHNSON, KNOPP, OLSEN, ROBLAN, THOMSEN, WHITSETT, WINTERS, Representative JOHNSON (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Prohibits discrimination based on age, expected length of life, present or predicted disability, degree of medical dependency or quality of life in issuance of health benefit plans and in determination of medical services covered by state medical assistance program. Applies to health benefit plans in force on January 2, 2015.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to discrimination; creating new provisions; amending ORS 414.065, 414.690, 743.734, 743.736, 743.752, 743.754, 743.757 and 743.766; and declaring an emergency.

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

SECTION 1. ORS 414.065 is amended to read:

414.065. (1)(a) With respect to health care and services to be provided in medical assistance during any period, the Oregon Health Authority shall determine, subject to such revisions as it may make from time to time and subject to legislative funding and paragraph (b) of this subsection:

(A) The types and extent of health care and services to be provided to each eligible group of recipients of medical assistance.

(B) Standards, including outcome and quality measures, to be observed in the provision of health care and services.

(C) The number of days of health care and services toward the cost of which medical assistance funds will be expended in the care of any person.

(D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing health services to an applicant or recipient.

(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(F) The amount and application of any copayment or other similar cost-sharing payment that the authority may require a recipient to pay toward the cost of health care or services.

(b) The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

(2) The types and extent of health care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the authority and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from medical assistance funds available to providers of health care and services in meeting the costs thereof.

(3) Except for payments under a cost-sharing plan, payments made by the authority for medical assistance shall constitute payment in full for all health care and services for which such payments

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

of medical assistance were made.

(4) Notwithstanding subsections (1) and (2) of this section, the Department of Human Services shall be responsible for determining the payment for Medicaid-funded long term care services and for contracting with the providers of long term care services.

(5) In determining a global budget for a coordinated care organization:

(a) The allocation of the payment, the risk and any cost savings shall be determined by the governing body of the organization;

(b) The authority shall consider the community health assessment conducted by the organization and reviewed annually, and the organization's health care costs; and

(c) The authority shall take into account the organization's provision of innovative, nontraditional health services.

(6) Under the supervision of the Governor, the authority may work with the Centers for Medicare and Medicaid Services to develop, in addition to global budgets, payment streams:

(a) To support improved delivery of health care to recipients of medical assistance; and

(b) That are funded by coordinated care organizations, counties or other entities other than the state whose contributions qualify for federal matching funds under Title XIX or XXI of the Social Security Act.

(7) In determining the types and extent of health care and services to be provided to each eligible group of recipients of medical assistance, the authority:

(a) Must take into account the health care needs of diverse segments of Oregon's population; and

(b) Must ensure that the services are not denied to an individual on the basis of the individual's age, expected length of life, present or predicted disability, degree of medical dependency or quality of life.

SECTION 2. ORS 414.690 is amended to read:

414.690. (1) The Health Evidence Review Commission shall regularly solicit testimony and information from stakeholders representing consumers, advocates, providers, carriers and employers in conducting the work of the commission.

(2) The commission shall actively solicit public involvement through a public meeting process to guide health resource allocation decisions.

(3)**(a)** The commission shall develop and maintain a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the population to be served. **In determining the priority of services on the list, the commission:**

(A) Must take into account the health care needs of diverse segments of Oregon's population; and

(B) Must ensure that the priority of a service is assessed independent of the age, expected length of life, present or predicted disability, degree of medical dependency or quality of life of the population to be served.

(b) The list must be submitted by the commission pursuant to subsection (5) of this section and is not subject to alteration by any other state agency.

(4) In order to encourage effective and efficient medical evaluation and treatment, the commission:

(a) May include clinical practice guidelines in its prioritized list of services. The commission shall actively solicit testimony and information from the medical community and the public to build

a consensus on clinical practice guidelines developed by the commission.

(b) May include statements of intent in its prioritized list of services. Statements of intent should give direction on coverage decisions where medical codes and clinical practice guidelines cannot convey the intent of the commission.

(c) Shall consider both the clinical effectiveness and cost-effectiveness of health services, including drug therapies, in determining their relative importance using peer-reviewed medical literature as defined in ORS 743A.060.

(5) The commission shall report the prioritized list of services to the Oregon Health Authority for budget determinations by July 1 of each even-numbered year.

(6) The commission shall make its report during each regular session of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Representatives and the President of the Senate.

(7) The commission may alter the list during the interim only as follows:

(a) To make technical changes to correct errors and omissions;

(b) To accommodate changes due to advancements in medical technology or new data regarding health outcomes;

(c) To accommodate changes to clinical practice guidelines; and

(d) To add statements of intent that clarify the prioritized list.

(8) If a service is deleted or added during an interim and no new funding is required, the commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the commission shall report to the Emergency Board to request the funding.

(9) The prioritized list of services remains in effect for a two-year period beginning no earlier than October 1 of each odd-numbered year.

SECTION 3. ORS 743.734 is amended to read:

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

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

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

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

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

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

(3)(a) A carrier may provide different health benefit plans to different categories of employees of a small employer when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status**, age, expected length of life, present or predicted disability, degree of medical dependency or quality of life** of such employees or their dependents. The categories must be based on bona fide employment-based classi-

fications that are consistent with the employer's usual business practice.

(b) Except as provided in ORS 743.736 (8), a carrier that offers coverage to a small employer shall offer coverage to all eligible employees of the small employer.

(c) If a small employer elects to offer coverage to dependents of eligible employees, the carrier shall offer coverage to all dependents of eligible employees.

(4) Notwithstanding any other provision of law, an insurer may not deny, delay or terminate participation of an individual in a group health benefit plan or exclude coverage otherwise provided to an individual under a group health benefit plan based on a preexisting condition of the individual.

SECTION 4. ORS 743.736 is amended to read:

743.736. (1) As a condition of transacting business in the small employer health insurance market in this state, a carrier shall offer small employers all of the carrier's health benefit plans, approved by the Department of Consumer and Business Services for use in the small employer market, for which the small employer is eligible.

(2) A carrier that offers a health benefit plan in the small employer market only to one or more bona fide associations is not required to offer that health benefit plan to small employers that are not members of the bona fide association.

(3) A carrier shall issue to a small employer any health benefit plan that is offered by the carrier if the small employer applies for the plan and agrees to make the required premium payments and to satisfy the other provisions of the health benefit plan.

(4) A multiple employer welfare arrangement, professional or trade association or other similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries may not issue coverage to a group or individual that is not in the same trade, business, profession or industry as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement may not include any requirements that relate to the actual or expected health status**, age, expected length of life, present or predicted disability, degree of medical dependency or quality of life** of the prospective enrollee.

(5) A carrier shall, pursuant to subsection (3) of this section, accept applications from and offer coverage to a small employer group covered under an existing health benefit plan regardless of whether a prospective enrollee is excluded from coverage under the existing plan because of late enrollment. When a carrier accepts an application for a small employer group, the carrier may continue to exclude the prospective enrollee excluded from coverage by the replaced plan until the prospective enrollee would have become eligible for coverage under that replaced plan.

(6) A carrier is not required to accept applications from and offer coverage pursuant to subsection (3) of this section if the department finds that acceptance of an application or applications would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

(7) A carrier shall market fairly all health benefit plans that are offered by the carrier to small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

(8)(a) Subsection (3) of this section does not require a carrier to offer coverage to or accept applications from:

(A) A small employer if the small employer is not physically located in the carrier's approved

service area;

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

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

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

(9) For purposes of ORS 743.733 to 743.737, except as provided in this subsection, carriers that are affiliated carriers or that are eligible to file a consolidated tax return pursuant to ORS 317.715 shall be treated as one carrier and any restrictions or limitations imposed by ORS 743.733 to 743.737 apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier. However, any insurance company or health maintenance organization that is an affiliate of a health care service contractor located in this state, or any health maintenance organization located in this state that is an affiliate of an insurance company or health care service contractor, may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area in this state may be considered a separate carrier.

(10) A carrier that elects to discontinue offering all of its health benefit plans to small employers under ORS 743.737 (3)(e), elects to discontinue renewing all such plans or elects to discontinue offering and renewing all such plans is prohibited from offering health benefit plans to small employers in this state for a period of five years from one of the following dates:

(a) The date of notice to the department pursuant to ORS 743.737 (3)(e); or

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

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

SECTION 5. ORS 743.752 is amended to read:

743.752. (1) Except in the case of a late enrollee and as otherwise provided in this section, a carrier offering a group health benefit plan to a group of two or more prospective certificate holders shall not decline to offer coverage to any eligible prospective enrollee and shall not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status**, age, expected length of life, present or predicted disability, degree of medical dependency or quality of life** of the enrollee.

(2) A carrier that elects to discontinue offering all of its group health benefit plans under ORS 743.754 (5)(e), elects to discontinue renewing all such plans or elects to discontinue offering and renewing all such plans is prohibited from offering health benefit plans in the group market in this state for a period of five years from one of the following dates:

(a) The date of notice to the Director of the Department of Consumer and Business Services pursuant to ORS 743.754 (5)(e); or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering group health benefit plans in this state.

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

(4) Nothing in this section shall prohibit an employer from providing different group health benefit plans to various categories of employees as defined by the employer nor prohibit an employer from providing health benefit plans through different carriers so long as the employer's categories of employees are established in a manner that does not relate to the actual or expected health status**, age, expected length of life, present or predicted disability, degree of medical dependency or quality of life** of the employees or their dependents.

(5) A multiple employer welfare arrangement, professional or trade association, or other similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries, shall not issue coverage to a group or individual that is not in the same trade, business, profession or industry or their subsidiaries as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement shall not include any requirements that relate to the actual or expected health status**, age, expected length of life, present or predicted disability, degree of medical dependency or quality of life** of the prospective enrollee.

SECTION 6. ORS 743.754 is amended to read:

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

(1) Except in the case of a late enrollee and except as otherwise provided in this section, a carrier offering a group health benefit plan may not decline to offer coverage to any eligible prospective enrollee and may not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status**, age, expected length of life, present or predicted disability, degree of medical dependency or quality of life** of the enrollee.

(2) A group health benefit plan may not apply a preexisting condition exclusion to any enrollee but may impose:

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

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

(3) Late enrollees may be subjected to a group eligibility waiting period that does not exceed 90 days.

(4) Each group health benefit plan shall contain a special enrollment period during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the Department of Consumer and Business Services.

(5) Each group health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder unless:

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

(b) The policyholder or, with respect to coverage of individual enrollees, an enrollee or a rep-

resentative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

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

(d) The policyholder fails to comply with the contribution requirements under the plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) The Director of the Department of Consumer and Business Services orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon

finding that the continuation of the coverage would:

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

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

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

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

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

(7) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind the coverage of an enrollee under a group health benefit plan unless:

(a) The enrollee:

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

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

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

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

(8) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind a group health benefit plan unless:

(a) The plan sponsor or a representative of the plan sponsor:

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

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

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

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

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

(10) A group health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

(11) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from a group not eligible for coverage under such a plan.

SECTION 7. ORS 743.757 is amended to read:

743.757. (1) As used in this section, "guaranteed association" means an association that:

(a) The Director of the Department of Consumer and Business Services has determined under ORS 743.524 meets the requirements described in ORS 731.098 (2); and

(b) Is a statewide nonprofit organization representing the interests of individuals licensed under ORS chapter 696.

(2) A carrier may offer a health benefit plan to a guaranteed association if the plan provides health benefits covering 500 or more members or dependents of members of the association.

(3) When a carrier offers coverage to a guaranteed association under subsection (2) of this section, the carrier shall offer coverage to all members of the association and all dependents of the members of the association without regard to the actual or expected health status**, age, expected length of life, present or predicted disability, degree of medical dependency or quality of life** of any member or any dependent of a member of the association.

(4) A carrier offering a health benefit plan under subsection (2) of this section shall establish premium rates as follows:

(a) For the initial 12-month period of coverage, the carrier shall submit to the director a certified statement that the premium rates charged to the guaranteed association are actuarially sound. The statement must be signed by an actuary certifying the accuracy of the rating methodology as established by the American Academy of Actuaries.

(b) For any subsequent 12-month period of coverage, according to a rating methodology as established by the American Academy of Actuaries.

(5) A member of a guaranteed association may apply for coverage offered by a carrier under subsection (2) of this section only:

(a) If the member has been an active member of the association for no less than 30 days;

(b) During an annual open enrollment period offered by the association; and

(c) After meeting any additional eligibility requirements agreed upon by the association and the carrier.

(6) Notwithstanding subsection (5) of this section, if a member or a dependent of a member of a guaranteed association terminates coverage under the health benefit plan, the member or dependent shall be excluded from coverage for 12 months from the date of termination of coverage. The member may enroll for coverage of the member or the dependent during an annual open enrollment period following the expiration of the exclusion period.

SECTION 8. ORS 743.766 is amended to read:

743.766. (1) With respect to coverage under an individual health benefit plan, a carrier:

(a) May not impose an individual coverage waiting period that exceeds 90 days.

(b) May impose an exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

(c) With respect to individual coverage under a grandfathered health plan, a carrier may not impose a preexisting condition exclusion unless the exclusion complies with the following requirements:

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

(B) The exclusion expires no later than six months after the individual's effective date of coverage.

(2) If the carrier elects to restrict coverage as described in subsection (1) of this section, the carrier shall reduce the duration of the period during which the restriction is imposed by an amount equal to the individual's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days after the effective date of coverage in the new

individual health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period.

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

(4) A carrier shall renew an individual health benefit plan, including a health benefit plan issued through a bona fide association, unless:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status**, age, expected length of life, present or predicted disability, degree of medical dependency or quality of life** of any current or prospective enrollee.

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

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

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

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

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

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

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

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

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

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

(8) An individual health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

(9) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from an individual not eligible for coverage under such a plan.

SECTION 9. The amendments to ORS 743.734, 743.736, 743.752, 743.754, 743.757 and 743.766 by sections 3 to 8 of this 2014 Act apply to health benefit plans that are in force on or after January 2, 2015.

SECTION 10. This 2014 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2014 Act takes effect on its passage.