

**B-Engrossed**  
**House Bill 2466**

Ordered by the Senate June 5  
Including House Amendments dated April 22 and Senate Amendments  
dated June 5

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of Governor John A. Kitzhaber, M.D., for Department of Consumer and Business Services)

**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.

Modifies requirements for health insurance [*consistent with federal law*].  
Declares emergency, effective on passage.

**A BILL FOR AN ACT**

1  
2 Relating to health insurance; creating new provisions; amending ORS 731.146, 743.106, 743.552,  
3 743.602, 743.730, 743.731, 743.734, 743.736, 743.737, 743.745, 743.751, 743.754, 743.766, 743.769,  
4 743.818, 743.826, 743.911, 743A.141, 750.003 and 750.055 and section 66, chapter 681, Oregon Laws  
5 2013; repealing ORS 743.775; and declaring an emergency.

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

7 **SECTION 1. Sections 2, 3 and 3a of this 2015 Act are added to and made a part of the**  
8 **Insurance Code.**

9 **SECTION 2. (1) As used in this section:**

10 (a) **“Carrier” has the meaning given that term in ORS 743.730.**

11 (b) **“Grandfathered health plan” has the meaning given that term in ORS 743.730.**

12 (c) **“Health benefit plan” has the meaning given that term in ORS 743.730.**

13 (d) **“Transitional grandfathered health benefit plan” means a grandfathered health plan**  
14 **that is issued or renewed by an employer with 51 to 100 employees.**

15 (e) **“Transitional health benefit plan” means a health benefit plan, other than a grandfa-**  
16 **thered health plan, that is:**

17 (A) **Before January 1, 2016, issued to or renewed by an employer with 51 to 100 employees**  
18 **on the date the plan is issued or renewed;**

19 (B) **In effect on December 31, 2015; and**

20 (C) **According to published federal guidance, not subject to enforcement by the United**  
21 **States Department of Health and Human Services, the United States Department of Labor**  
22 **or the United States Department of the Treasury, for compliance with the requirements of:**

23 (i) **42 U.S.C. 300gg;**

24 (ii) **42 U.S.C. 300gg-1;**

25 (iii) **42 U.S.C. 300gg-2;**

26 (iv) **42 U.S.C. 300gg-5;**

27 (v) **42 U.S.C. 300gg-6; and**

**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.

1 (vi) 42 U.S.C. 300gg-8.

2 (2) A transitional health benefit plan and a transitional grandfathered health benefit plan  
3 are not subject to the requirements:

4 (a) In ORS 742.005 (6) unless otherwise required by rule by the Department of Consumer  
5 and Business Services;

6 (b) In ORS 743.736;

7 (c) In ORS 743.737 (1)(a), (8), (10) and (11); and

8 (d) Imposing limitations on participation and contribution rates contained in ORS 743.737.

9 (3) On and after January 1, 2016, each transitional health benefit plan shall be renewable  
10 with respect to all eligible enrollees at the option of the policyholder, employer or contract  
11 holder unless the carrier discontinues both offering and renewing the health benefit plan in  
12 this state or in a specified service area within this state, other than a plan discontinued in  
13 a specified service area within this state:

14 (a) Because of the inability to reach an agreement with the health care providers or or-  
15 ganization of health care providers to provide services under the plan within the service  
16 area;

17 (b) That gives notice of the decision to discontinue the plan to the Department of Con-  
18 sumer and Business Services and to all policyholders covered by the plan;

19 (c) That does not cancel coverage under the plan for 90 days after the date of the notice  
20 required under paragraph (b) of this subsection; and

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

24 (4) ORS 743.752 (2) does not apply when a carrier discontinues a group health benefit plan  
25 due to the change in the definition of "small employer" from an employer with a maximum  
26 of 50 employees to an employer with a maximum of 100 employees.

27 (5) The Department of Consumer and Business Services may modify the requirements  
28 of this section or extend or delay the operative date of this section to the extent necessary  
29 to comply with published federal guidance described in subsection (1)(e)(C) of this section.

30 (6) No later than September 1, 2018, the department shall report to the appropriate in-  
31 terim committees of the Legislative Assembly on whether the repeal of this section by sec-  
32 tion 32 of this 2015 Act should be extended to a later date.

33 **SECTION 3.** Notwithstanding ORS 743.736, 743.737 and 743.754, a carrier is not required  
34 to actively market:

35 (1) A health benefit plan sold only to a bona fide association, to groups that are not  
36 members of the bona fide association;

37 (2) A grandfathered health plan, to a group or individual who is not eligible for coverage  
38 under the plan;

39 (3) A group health benefit plan, to a group that is not eligible for coverage under the  
40 plan;

41 (4) A qualified health plan sold only through the health insurance exchange, to an indi-  
42 vidual or group outside of the exchange; or

43 (5) A policy of group health insurance that may be delivered or issued for delivery in this  
44 state without the approval of the Director of the Department of Consumer and Business  
45 Services under ORS 742.003 (1).

1       **SECTION 3a.** (1) **The Department of Consumer and Business Services shall adopt by rule**  
2 **a method for determining whether:**

3       **(a) An employee is an eligible employee as defined in ORS 743.730; and**

4       **(b) An employer is a small employer as defined in ORS 743.730.**

5       **(2) The method adopted by the department under subsection (1) of this section must be**  
6 **consistent with corresponding federal requirements for the Small Business Health Options**  
7 **Program as defined in ORS 741.300.**

8       **SECTION 4.** ORS 731.146 is amended to read:

9       731.146. (1) "Transact insurance" means one or more of the following acts effected by mail or  
10 otherwise:

11       (a) Making or proposing to make an insurance contract.

12       (b) Taking or receiving any application for insurance.

13       (c) Receiving or collecting any premium, commission, membership fee, assessment, due or other  
14 consideration for any insurance or any part thereof.

15       (d) Issuing or delivering policies of insurance.

16       (e) Directly or indirectly acting as an insurance producer for, or otherwise representing or aid-  
17 ing on behalf of another, any person in the solicitation, negotiation, procurement or effectuation of  
18 insurance or renewals thereof, the dissemination of information as to coverage or rates, the for-  
19 warding of applications, the delivering of policies, the inspection of risks, the fixing of rates, the  
20 investigation or adjustment of claims or losses, the transaction of matters subsequent to effectuation  
21 of the policy and arising out of it, or in any other manner representing or assisting a person with  
22 respect to insurance.

23       (f) Advertising locally or circularizing therein without regard for the source of such  
24 circularization, whenever such advertising or circularization is for the purpose of solicitation of in-  
25 surance business.

26       (g) Doing any other kind of business specifically recognized as constituting the doing of an in-  
27 surance business within the meaning of the Insurance Code.

28       (h) Offering [*individual or small group coverage under a multistate health benefit plan, as defined*  
29 *in ORS 743.730*] **a multistate qualified health plan to individuals or small employers through**  
30 **the program administered by the United States Office of Personnel Management pursuant**  
31 **to 42 U.S.C. 18054.**

32       (i) Doing or proposing to do any insurance business in substance equivalent to any of para-  
33 graphs (a) to (h) of this subsection in a manner designed to evade the provisions of the Insurance  
34 Code.

35       (2) Subsection (1) of this section does not include, apply to or affect the following:

36       (a) Making investments within a state by an insurer not admitted or authorized to do business  
37 within such state.

38       (b) Except as provided in ORS 743.015, doing or proposing to do any insurance business arising  
39 out of a policy of group life insurance or a policy of blanket health insurance, if the master policy  
40 was validly issued to cover a group organized primarily for purposes other than the procurement  
41 of insurance and was delivered in and pursuant to the laws of another state in which:

42       (A) The insurer was authorized to do an insurance business;

43       (B) The policyholder is domiciled or otherwise has a bona fide situs; and

44       (C) With respect to a policy of blanket health insurance, the policy was approved by the director  
45 of such state.

1 (c) Investigating, settling, or litigating claims under policies lawfully written within a state, or  
2 liquidating assets and liabilities, all resulting from the insurer's former authorized operations within  
3 such state.

4 (d) Transactions within a state under a policy subsequent to its issuance if the policy was law-  
5 fully solicited, written and delivered outside the state and did not cover a subject of insurance res-  
6 ident, located or to be performed in the state when issued.

7 (e) The continuation and servicing of life or health insurance policies remaining in force on  
8 residents of a state if the insurer has withdrawn from such state and is not transacting new insur-  
9 ance therein.

10 (3) If mail is used, an act shall be deemed to take place at the point where the matter trans-  
11 mitted by mail is delivered and takes effect.

12 **SECTION 5.** ORS 743.106 is amended to read:

13 743.106. (1) No policy form shall be delivered or issued for delivery in this state unless:

14 (a) The policy text achieves a score of 40 or more on the Flesch reading ease test, or an  
15 equivalent score on any comparable test as provided in subsection (3) of this section;

16 (b) The policy, except for specification pages, schedules and tables is printed in not less than  
17 **12-point type, 13-point leading for health benefit plans, as defined in ORS 743.730, and 10-point**  
18 **type, [one point leaded] 11-point leading for all other policies;**

19 (c) The style, arrangement and overall appearance of the policy give no undue prominence to  
20 any portion of the text, including the text of any indorsements or riders; and

21 (d) The policy contains a table of contents or an index of the principal sections of the policy,  
22 if the policy has more than 3,000 words of text printed on three or less pages, or regardless of the  
23 number of words if the policy has more than three pages.

24 (2) For the purposes of this section, a Flesch reading ease test score shall be calculated as fol-  
25 lows:

26 (a) For policy forms containing 10,000 words or less of text, the entire form shall be analyzed.  
27 For policy forms containing more than 10,000 words, two 200-word samples per page may be ana-  
28 lyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.

29 (b) The number of words and sentences in the text shall be counted and the total number of  
30 words divided by the total number of sentences. The figure obtained shall be multiplied by a factor  
31 of 1.015.

32 (c) The total number of syllables in the text shall be counted and divided by the total number  
33 of words. The figure obtained shall be multiplied by a factor of 84.6.

34 (d) The sum of the figures computed under paragraphs (b) and (c) of this subsection subtracted  
35 from 206.835 equals the Flesch reading ease test score for the policy form.

36 (e) For purposes of paragraphs (b) and (c) of this subsection, the following procedures shall be  
37 used:

38 (A) A contraction, hyphenated word or numbers and letters, when separated by spaces, shall be  
39 counted as one word.

40 (B) A unit of words ending with a period, semicolon or colon shall be counted as a sentence.

41 (C) A "syllable" means a unit of spoken language consisting of one or more letters of a word  
42 as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pro-  
43 nunciations of a word, the pronunciation containing fewer syllables may be used.

44 (f) As used in this section, "text" includes all written matter except the following:

45 (A) The name and address of the insurer; the name, number or title of the policy; the table of

1 contents or index; captions and subcaptions; specification pages; schedules or tables; and

2 (B) Policy language drafted to conform to the requirements of any state or federal law, regu-  
3 lation or agency interpretation; policy language required by any collectively bargained agreement;  
4 medical terminology; and words that are defined in the policy. However, the insurer shall identify  
5 the language or terminology excepted by this subparagraph and shall certify in writing that the  
6 language or terminology is entitled to be excepted by this subparagraph.

7 (3) Any other reading test may be approved by the Director of the Department of Consumer and  
8 Business Services as an alternative to the Flesch reading ease test if it is comparable in result to  
9 the Flesch reading ease test.

10 (4) Each policy filing shall be accompanied by a certificate signed by an officer of the insurer  
11 stating that the policy meets the minimum required reading ease score on the test used, or stating  
12 that the score is lower than the minimum required but should be authorized in accordance with ORS  
13 743.107. To confirm the accuracy of a certification, the director may require the submission of fur-  
14 ther information.

15 (5) At the option of the insurer, riders, indorsements, applications and other forms made a part  
16 of the policy may be scored as separate forms or as part of the policy with which they may be used.

17 **SECTION 6.** ORS 743.552 is amended to read:

18 743.552. The Director of the Department of Consumer and Business Services shall by rule es-  
19 tablish guidelines for the coordination of benefits for individual and [*small*] group health insurance,  
20 including:

21 (1) The procedures by which persons insured under the policies are to be made aware of the  
22 existence of a coordination of benefits provision;

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

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

25 (4) Establishment of the order of benefit determination; and

26 (5) Reasonable claim administration procedures to expedite claim payments.

27 **SECTION 7.** ORS 743.602 is amended to read:

28 743.602. If a legally separated, divorced or surviving spouse elects continuation of coverage un-  
29 der ORS 743.601 (1) to (6):

30 (1) The monthly premium for the continuation shall not be greater than the amount that would  
31 be charged if the legally separated, divorced or surviving spouse were a current certificate holder  
32 of the group plan plus the amount that the group policyholder would contribute toward the premium  
33 if the legally separated, divorced or surviving spouse were a certificate holder of the group plan,  
34 plus an additional amount not to exceed two percent of the certificate holder and group plan holder  
35 contributions, for the costs of administration.

36 (2) The first premium shall be paid by the legally separated, divorced or surviving spouse within  
37 45 days of the date of the election.

38 (3) The right to continuation of coverage shall terminate upon the earliest of any of the fol-  
39 lowing:

40 (a) The failure to pay premiums when due, including any grace period allowed by the policy;

41 (b) The date that the group policy is terminated as to all group members except that if a dif-  
42 ferent group policy is made available to group members, the legally separated, divorced or surviving  
43 spouse shall be eligible for continuation of coverage as if the original policy had not been termi-  
44 nated;

45 (c) The date on which the legally separated, divorced or surviving spouse becomes insured under

1 any other group health plan;

2 (d) The date on which the legally separated[,] **or** divorced [*or surviving*] spouse remarries [*and*  
3 *becomes covered under another group health plan*]; or

4 (e) The date on which the legally separated, divorced or surviving spouse becomes eligible for  
5 federal Medicare coverage.

6 **SECTION 8.** ORS 743.730 is amended to read:

7 743.730. For purposes of ORS 743.730 to 743.773 **and 743.818 and section 3 of this 2015 Act:**

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

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

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

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

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

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

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

27 (4) "Bona fide association" means an association that:

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

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

30 (c) Does not condition membership in the association on any factor relating to the health status  
31 of an individual or the individual's dependent or employee;

32 (d) Makes health insurance coverage that is offered through the association available to all  
33 members of the association regardless of the health status of the member or individuals who are  
34 eligible for coverage through the member;

35 (e) Does not make health insurance coverage that is offered through the association available  
36 other than in connection with a member of the association;

37 (f) Has a constitution and bylaws; and

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

39 (5) "Carrier" means any person who provides health benefit plans in this state, including:

40 (a) A licensed insurance company;

41 (b) A health care service contractor;

42 (c) A health maintenance organization;

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

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

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

3 (e) Any other person or corporation responsible for the payment of benefits or provision of ser-  
4 vices.

5 (6) “Catastrophic plan” means a health benefit plan that meets the requirements for a cat-  
6 astrophobic plan under 42 U.S.C. 18022(e) [*and that is offered through the Oregon health insurance*  
7 *exchange*].

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

11 [(8)] (7) “Dependent” means the spouse or child of an eligible employee, subject to applicable  
12 terms of the health benefit plan covering the employee.

13 [(9)] (8) “Eligible employee” means an employee who [*works on a regularly scheduled basis, with*  
14 *a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility*  
15 *between 17.5 and 40 hours per week subject to rules of the carrier. “Eligible employee” does not include*  
16 *employees who work on a temporary, seasonal or substitute basis. Employees who have been employed*  
17 *by the employer for fewer than 90 days are not eligible employees unless the employer so allows]* **is**  
18 **eligible for coverage under a group health benefit plan.**

19 [(10)] (9) “Employee” means any individual employed by an employer.

20 [(11)] (10) “Enrollee” means an employee, dependent of the employee or an individual otherwise  
21 eligible for a group or individual health benefit plan who has enrolled for coverage under the terms  
22 of the plan.

23 [(12)] (11) “Exchange” means the health insurance exchange administered by the Oregon Health  
24 Insurance Exchange Corporation in accordance with ORS 741.310.

25 [(13)] (12) “Exclusion period” means a period during which specified treatments or services are  
26 excluded from coverage.

27 [(14)] (13) “Financial impairment” means that a carrier is not insolvent and is:

- 28 (a) Considered by the director to be potentially unable to fulfill its contractual obligations; or
- 29 (b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

30 [(15)(a)] (14)(a) “Geographic average rate” means the arithmetical average of the lowest pre-  
31 mium and the corresponding highest premium to be charged by a carrier in a geographic area es-  
32 tablished by the director for the carrier’s:

- 33 (A) Group health benefit plans offered to small employers; or
- 34 (B) Individual health benefit plans.

35 (b) “Geographic average rate” does not include premium differences that are due to differences  
36 in benefit design, age, tobacco use or family composition.

37 [(16)] (15) “Grandfathered health plan” has the meaning prescribed by the United States Secre-  
38 taries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

39 [(17)] (16) “Group eligibility waiting period” means, with respect to a group health benefit plan,  
40 the period of employment or membership with the group that a prospective enrollee must complete  
41 before plan coverage begins.

42 [(18)(a)] (17)(a) “Health benefit plan” means any:

- 43 (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;
- 44 (B) **Subscriber contract of a health care service contractor** [*or health maintenance organization*  
45 *subscriber contract*] **as defined in ORS 750.005**; or

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

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

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

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

7 (C) Medicare supplement insurance policies;

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

9 (E) Benefits delivered through a flexible spending arrangement established pursuant to section  
10 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition  
11 to a group health benefit plan;

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

14 (G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity in-  
15 surance;

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

18 (I) Dental only coverage;

19 (J) Vision only coverage;

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

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

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

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

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

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

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

33 [(20)] (18) "Individual health benefit plan" means a health benefit plan:

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

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

37 [(21)] (19) "Initial enrollment period" means a period of at least 30 days following commence-  
38 ment of the first eligibility period for an individual.

39 [(22)] (20) "Late enrollee" means an individual who enrolls in a group health benefit plan sub-  
40 sequent to the initial enrollment period during which the individual was eligible for coverage but  
41 declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

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

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

45 (c) A court issues an order that coverage be provided for a spouse or minor child under an



1 employee's employer sponsored health benefit plan and request for enrollment is made within 30  
2 days after issuance of the court order;

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

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

9 [(23)] **(21)** "Minimal essential coverage" has the meaning given that term in section 5000A(f) of  
10 the Internal Revenue Code.

11 [(24)] **(22)** "Multiple employer welfare arrangement" means a multiple employer welfare ar-  
12 rangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974,  
13 as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

14 [(25)] **(23)** "Preexisting condition exclusion" means:

15 (a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of  
16 coverage based on a medical condition being present before the effective date of coverage or before  
17 the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was  
18 recommended or received for the condition before the date of coverage or denial of coverage.

19 (b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late  
20 enrollee that excludes coverage for services, charges or expenses incurred during a specified period  
21 immediately following enrollment for a condition for which medical advice, diagnosis, care or treat-  
22 ment was recommended or received during a specified period immediately preceding enrollment. For  
23 purposes of this paragraph pregnancy and genetic information do not constitute preexisting condi-  
24 tions.

25 [(26)] **(24)** "Premium" includes insurance premiums or other fees charged for a health benefit  
26 plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees cov-  
27 ered by the plan.

28 [(27)] **(25)** "Rating period" means the 12-month calendar period for which premium rates estab-  
29 lished by a carrier are in effect, as determined by the carrier.

30 [(28)] **(26)** "Representative" does not include an insurance producer or an employee or author-  
31 ized representative of an insurance producer or carrier.

32 [(29)(a)] *"Small employer" means an employer that employed an average of at least one but not more  
33 than 50 employees on business days during the preceding calendar year, the majority of whom are  
34 employed within this state, and that employs at least one eligible employee on the first day of the plan  
35 year.]*

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

38 [(c)] *The determination of whether an employer that was not in existence throughout the preceding  
39 calendar year is a small employer shall be based on the average number of employees that it is rea-  
40 sonably expected the employer will employ on business days in the current calendar year.]*

41 **(27) "Small employer" has the meaning given that term in 42 U.S.C. 18024 unless other-  
42 wise prescribed by the department by rule in accordance with guidance issued by the United  
43 States Department of Health and Human Services, the United States Department of Labor  
44 or the United States Department of the Treasury.**

45 **SECTION 9.** ORS 743.730, as amended by section 59, chapter 681, Oregon Laws 2013, is

1 amended to read:

2 743.730. For purposes of ORS 743.730 to 743.773 **and 743.818 and section 3 of this 2015 Act:**

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

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

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

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

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

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

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

22 (4) "Bona fide association" means an association that:

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

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

25 (c) Does not condition membership in the association on any factor relating to the health status  
26 of an individual or the individual's dependent or employee;

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

30 (e) Does not make health insurance coverage that is offered through the association available  
31 other than in connection with a member of the association;

32 (f) Has a constitution and bylaws; and

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

34 (5) "Carrier" means any person who provides health benefit plans in this state, including:

35 (a) A licensed insurance company;

36 (b) A health care service contractor;

37 (c) A health maintenance organization;

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

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

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

43 (e) Any other person or corporation responsible for the payment of benefits or provision of ser-  
44 vices.

45 (6) "Catastrophic plan" means a health benefit plan that meets the requirements for a cat-

1 astrophic plan under 42 U.S.C. 18022(e) [and that is offered through the Oregon health insurance  
2 exchange].

3 [(7) “Creditable coverage” means prior health care coverage as defined in 42 U.S.C. 300gg as  
4 amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the  
5 enrollee obtains new coverage.]

6 [(8)] (7) “Dependent” means the spouse or child of an eligible employee, subject to applicable  
7 terms of the health benefit plan covering the employee.

8 [(9)] (8) “Eligible employee” means an employee who [works on a regularly scheduled basis, with  
9 a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility  
10 between 17.5 and 40 hours per week subject to rules of the carrier. “Eligible employee” does not include  
11 employees who work on a temporary, seasonal or substitute basis. Employees who have been employed  
12 by the employer for fewer than 90 days are not eligible employees unless the employer so allows] **is**  
13 **eligible for coverage under a group health benefit plan.**

14 [(10)] (9) “Employee” means any individual employed by an employer.

15 [(11)] (10) “Enrollee” means an employee, dependent of the employee or an individual otherwise  
16 eligible for a group or individual health benefit plan who has enrolled for coverage under the terms  
17 of the plan.

18 [(12)] (11) “Exchange” means the health insurance exchange administered by the Oregon Health  
19 Insurance Exchange Corporation in accordance with ORS 741.310.

20 [(13)] (12) “Exclusion period” means a period during which specified treatments or services are  
21 excluded from coverage.

22 [(14)] (13) “Financial impairment” means that a carrier is not insolvent and is:

- 23 (a) Considered by the director to be potentially unable to fulfill its contractual obligations; or  
24 (b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

25 [(15)(a)] (14)(a) “Geographic average rate” means the arithmetical average of the lowest pre-  
26 mium and the corresponding highest premium to be charged by a carrier in a geographic area es-  
27 tablished by the director for the carrier’s:

- 28 (A) Group health benefit plans offered to small employers; or  
29 (B) Individual health benefit plans.

30 (b) “Geographic average rate” does not include premium differences that are due to differences  
31 in benefit design, age, tobacco use or family composition.

32 [(16)] (15) “Grandfathered health plan” has the meaning prescribed by the United States Secre-  
33 taries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

34 [(17)] (16) “Group eligibility waiting period” means, with respect to a group health benefit plan,  
35 the period of employment or membership with the group that a prospective enrollee must complete  
36 before plan coverage begins.

37 [(18)(a)] (17)(a) “Health benefit plan” means any:

- 38 (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;  
39 (B) **Subscriber contract of a health care service contractor [or health maintenance organization**  
40 **subscriber contract] as defined in ORS 750.005;** or

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

44 (b) “Health benefit plan” does not include:

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

- 1 (B) Coverage of Medicare services pursuant to contracts with the federal government;  
2 (C) Medicare supplement insurance policies;  
3 (D) Coverage of TRICARE services pursuant to contracts with the federal government;  
4 (E) Benefits delivered through a flexible spending arrangement established pursuant to section  
5 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition  
6 to a group health benefit plan;  
7 (F) Separately offered long term care insurance, including, but not limited to, coverage of nurs-  
8 ing home care, home health care and community-based care;  
9 (G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity in-  
10 surance;  
11 (H) Short term health insurance policies that are in effect for periods of 12 months or less, in-  
12 cluding the term of a renewal of the policy;  
13 (I) Dental only coverage;  
14 (J) Vision only coverage;  
15 (K) Stop-loss coverage that meets the requirements of ORS 742.065;  
16 (L) Coverage issued as a supplement to liability insurance;  
17 (M) Insurance arising out of a workers' compensation or similar law;  
18 (N) Automobile medical payment insurance or insurance under which benefits are payable with  
19 or without regard to fault and that is statutorily required to be contained in any liability insurance  
20 policy or equivalent self-insurance; or  
21 (O) Any employee welfare benefit plan that is exempt from state regulation because of the fed-  
22 eral Employee Retirement Income Security Act of 1974, as amended.  
23 (c) For purposes of this subsection, renewal of a short term health insurance policy includes the  
24 issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days  
25 after the expiration of a policy previously issued by the insurer to the policyholder.  
26 [(19) "Individual coverage waiting period" means a period in an individual health benefit plan  
27 during which no premiums may be collected and health benefit plan coverage issued is not effective.]  
28 [(20)] (18) "Individual health benefit plan" means a health benefit plan:  
29 (a) That is issued to an individual policyholder; or  
30 (b) That provides individual coverage through a trust, association or similar group, regardless  
31 of the situs of the policy or contract.  
32 [(21)] (19) "Initial enrollment period" means a period of at least 30 days following commence-  
33 ment of the first eligibility period for an individual.  
34 [(22)] (20) "Late enrollee" means an individual who enrolls in a group health benefit plan sub-  
35 sequent to the initial enrollment period during which the individual was eligible for coverage but  
36 declined to enroll. However, an eligible individual shall not be considered a late enrollee if:  
37 (a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg  
38 or as prescribed by rule by the Department of Consumer and Business Services;  
39 (b) The individual applies for coverage during an open enrollment period;  
40 (c) A court issues an order that coverage be provided for a spouse or minor child under an  
41 employee's employer sponsored health benefit plan and request for enrollment is made within 30  
42 days after issuance of the court order;  
43 (d) The individual is employed by an employer that offers multiple health benefit plans and the  
44 individual elects a different health benefit plan during an open enrollment period; or  
45 (e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a

1 publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance  
2 program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for  
3 coverage in a group health benefit plan.

4 [(23)] (21) “Minimal essential coverage” has the meaning given that term in section 5000A(f) of  
5 the Internal Revenue Code.

6 [(24)] (22) “Multiple employer welfare arrangement” means a multiple employer welfare ar-  
7 rangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974,  
8 as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

9 [(25)] (23) “Preexisting condition exclusion” means:

10 (a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of  
11 coverage based on a medical condition being present before the effective date of coverage or before  
12 the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was  
13 recommended or received for the condition before the date of coverage or denial of coverage.

14 (b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late  
15 enrollee that excludes coverage for services, charges or expenses incurred during a specified period  
16 immediately following enrollment for a condition for which medical advice, diagnosis, care or treat-  
17 ment was recommended or received during a specified period immediately preceding enrollment. For  
18 purposes of this paragraph pregnancy and genetic information do not constitute preexisting condi-  
19 tions.

20 [(26)] (24) “Premium” includes insurance premiums or other fees charged for a health benefit  
21 plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees cov-  
22 ered by the plan.

23 [(27)] (25) “Rating period” means the 12-month calendar period for which premium rates estab-  
24 lished by a carrier are in effect, as determined by the carrier.

25 [(28)] (26) “Representative” does not include an insurance producer or an employee or author-  
26 ized representative of an insurance producer or carrier.

27 [(29)(a) “Small employer” means an employer that employed an average of at least one but not more  
28 than 100 employees on business days during the preceding calendar year, the majority of whom are  
29 employed within this state, and that employs at least one eligible employee on the first day of the plan  
30 year.]

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

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

36 (27) “Small employer” has the meaning given that term in 42 U.S.C. 18024 unless other-  
37 wise prescribed by the department by rule in accordance with guidance issued by the United  
38 States Department of Health and Human Services, the United States Department of Labor  
39 or the United States Department of the Treasury.

40 **SECTION 10.** Section 66, chapter 681, Oregon Laws 2013, is amended to read:

41 **Sec. 66.** (1)(a) The amendments to ORS 743.730 by section 17, [of this 2013 Act] **chapter 681,**  
42 **Oregon Laws 2013,** become operative January 2, 2014.

43 (b) The amendments to ORS 743.730 by section 59, [of this 2013 Act] **chapter 681, Oregon Laws**  
44 **2013,** become operative January [2] 1, 2016.

45 (2) The amendments to ORS 731.146, 743.734 and 743.822 by sections 9, 20 and 31, [of this 2013

1 Act] **chapter 681, Oregon Laws 2013**, become operative January 2, 2014.

2 **SECTION 11.** ORS 743.731 is amended to read:

3 743.731. The purposes of ORS 743.730 to 743.773 and 743.923 are:

4 (1) To promote the availability of health insurance coverage to groups regardless of their  
5 enrollees' health status or claims experience;

6 (2) To prevent abusive rating practices;

7 (3) To require disclosure of rating practices to purchasers of small employer and individual  
8 health benefit plans;

9 (4) To prohibit the use of preexisting condition exclusions except in **individual** grandfathered  
10 health plans;

11 (5) To encourage the availability of individual health benefit plans for individuals who are not  
12 enrolled in group health benefit plans;

13 (6) To improve renewability and continuity of coverage for employers and covered individuals;

14 (7) To improve the efficiency and fairness of the health insurance marketplace; and

15 (8) To ensure that health insurance coverage in Oregon satisfies the requirements of the Health  
16 Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and the Patient Protection and  
17 Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act  
18 (P.L. 111-152), and that enforcement authority for those requirements is retained by the Director of  
19 the Department of Consumer and Business Services.

20 **SECTION 12.** ORS 743.734 is amended to read:

21 743.734. (1) Every health benefit plan shall be subject to the provisions of ORS 743.733 to  
22 743.737, if the plan provides health benefits covering one or more employees of a small employer and  
23 if any one of the following conditions is met:

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

27 (b) The health benefit plan is treated by the employer or any of the [*eligible*] employees as part  
28 of a plan or program for the purposes of section 106, section 125 or section 162 of the Internal Re-  
29 venue Code of 1986, as amended.

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

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

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

36 (3)(a) A carrier may provide different health benefit plans to different categories of employees  
37 of a small employer when the employer has chosen to establish different categories of employees in  
38 a manner that does not relate to the actual or expected health status of such employees or their  
39 dependents. The categories must be based on bona fide employment-based classifications that are  
40 consistent with the employer's usual business practice.

41 (b) Except as provided in ORS 743.736 [(8)] (7), a carrier that offers coverage to a small em-  
42 ployer shall offer coverage to all eligible employees of the small employer.

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

45 (4) [*Notwithstanding any other provision of law,*] An insurer may not deny, delay or terminate

1 participation of an individual in a group health benefit plan or exclude coverage otherwise provided  
2 to an individual under a group health benefit plan based on a preexisting condition of the individual.

3 **SECTION 13.** ORS 743.736 is amended to read:

4 743.736. (1) As a condition of transacting business in the small employer health insurance mar-  
5 ket in this state, a carrier shall offer small employers all of the carrier's health benefit plans, ap-  
6 proved by the Department of Consumer and Business Services for use in the small employer market,  
7 for which the small employer is eligible.

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

11 *[(3)]* (2) A carrier shall issue to a small employer any health benefit plan that is offered by the  
12 carrier if the small employer applies for the plan and agrees to make the required premium pay-  
13 ments and to satisfy the other provisions of the health benefit plan.

14 *[(4)]* (3) A multiple employer welfare arrangement, professional or trade association or other  
15 similar arrangement established or maintained to provide benefits to a particular trade, business,  
16 profession or industry or their subsidiaries may not issue coverage to a group or individual that is  
17 not in the same trade, business, profession or industry as that covered by the arrangement. The  
18 arrangement shall accept all groups and individuals in the same trade, business, profession or in-  
19 dustry or their subsidiaries that apply for coverage under the arrangement and that meet the re-  
20 quirements for membership in the arrangement. For purposes of this subsection, the requirements  
21 for membership in an arrangement may not include any requirements that relate to the actual or  
22 expected health status of the prospective enrollee.

23 *[(5)]* (4) A carrier shall, pursuant to subsection *[(3)]* (2) of this section, accept applications from  
24 and offer coverage to a small employer group covered under an existing health benefit plan re-  
25 gardless of whether a prospective enrollee is excluded from coverage under the existing plan be-  
26 cause of late enrollment. When a carrier accepts an application for a small employer group, the  
27 carrier may continue to exclude the prospective enrollee excluded from coverage by the replaced  
28 plan until the prospective enrollee would have become eligible for coverage under that replaced  
29 plan.

30 *[(6)]* (5) A carrier is not required to accept applications from and offer coverage pursuant to  
31 subsection *[(3)]* (2) of this section if the department finds that acceptance of an application or ap-  
32 plications would endanger the carrier's ability to fulfill its contractual obligations or result in fi-  
33 nancial impairment of the carrier.

34 *[(7)]* (6) A carrier shall **actively** market *[fairly]* all health benefit plans that are offered by the  
35 carrier to small employers in the geographical areas in which the carrier makes coverage available  
36 or provides benefits.

37 *[(8)(a)]* (7)(a) Subsection *[(3)]* (2) of this section does not require a carrier to offer coverage to  
38 or accept applications from:

39 (A) A small employer if the small employer is not physically located in the carrier's approved  
40 service area;

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

43 (C) Small employers located within an area where the carrier reasonably anticipates, and dem-  
44 onstrates to the department, that it will not have the capacity in its network of providers to deliver  
45 services adequately to the enrollees of those small employer groups because of its obligations to

1 existing small employer group contract holders and enrollees.

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

5 [(9)] (8) For purposes of ORS 743.733 to 743.737, except as provided in this subsection, carriers  
6 that are affiliated carriers or that are eligible to file a consolidated tax return pursuant to ORS  
7 317.715 shall be treated as one carrier and any restrictions or limitations imposed by ORS 743.733  
8 to 743.737 apply as if all health benefit plans delivered or issued for delivery to small employers in  
9 this state by the affiliated carriers were issued by one carrier. However, any insurance company or  
10 health maintenance organization that is an affiliate of a health care service contractor located in  
11 this state, or any health maintenance organization located in this state that is an affiliate of an in-  
12 surance company or health care service contractor, may treat the health maintenance organization  
13 as a separate carrier and each health maintenance organization that operates only one health  
14 maintenance organization in a service area in this state may be considered a separate carrier.

15 [(10)] (9) A carrier that elects to discontinue offering all of its health benefit plans to small  
16 employers under ORS 743.737 (3)(e),<sup>L</sup> or elects to discontinue renewing all such plans [*or elects to*  
17 *discontinue offering and renewing all such plans*] is prohibited from offering health benefit plans to  
18 small employers in this state for a period of five years from one of the following dates:

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

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

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

27 **SECTION 14.** ORS 743.737 is amended to read:

28 743.737. (1) A health benefit plan issued to a small employer:

29 (a) **Other than a grandfathered health plan**, must cover essential health benefits consistent  
30 with 42 U.S.C. 300gg-11.

31 (b) May[.]

32 [(A)] require an affiliation period that does not exceed two months for an enrollee or 90 days  
33 for a late enrollee[;].

34 [(B) *Impose an exclusion period for specified covered services, as established under ORS 743.745,*  
35 *applicable to all individuals enrolling for the first time in the small employer health benefit plan; or*]

36 [(C)] (c) **May** not apply a preexisting condition exclusion to any enrollee.

37 (2) Late enrollees in a small employer health benefit plan may be subjected to a group eligibility  
38 waiting period that does not exceed 90 days.

39 (3) Each small employer health benefit plan shall be renewable with respect to all eligible  
40 enrollees at the option of the policyholder, small employer or contract holder unless:

41 (a) The policyholder, small employer or contract holder fails to pay the required premiums.

42 (b) The policyholder, small employer or contract holder or, with respect to coverage of individ-  
43 ual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an inten-  
44 tional misrepresentation of a material fact as prohibited by the terms of the plan.

45 (c) The number of enrollees covered under the plan is less than the number or percentage of



1 enrollees required by participation requirements under the plan.

2 (d) The small employer fails to comply with the contribution requirements under the health  
3 benefit plan.

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

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

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

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

16 [*D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans is-*  
17 *ssued by the carrier in the small employer market in this state or in the specified service area.*]

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

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

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

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

29 (g) The carrier discontinues [*offering or renewing, or*] **both** offering and renewing[,] a health  
30 benefit plan, other than a grandfathered health plan, for all small employers in this state or in a  
31 specified service area within this state, other than a plan discontinued under paragraph (f) of this  
32 subsection.

33 (h) The carrier discontinues [*renewing or*] **both** offering and renewing a grandfathered health  
34 plan for all small employers in this state or in a specified service area within this state, other than  
35 a plan discontinued under paragraph (f) of this subsection.

36 (i) With respect to plans that are being discontinued under paragraph (g) or (h) of this sub-  
37 section, the carrier must:

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

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

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

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

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

1 finding that the continuation of the coverage would:

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

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

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

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

10 (4) A carrier may modify a small employer health benefit plan at the time of coverage renewal.  
11 The modification is not a discontinuation of the plan under subsection (3)(e), (g) and (h) of this sec-  
12 tion.

13 (5) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may  
14 not rescind the coverage of an enrollee in a small employer health benefit plan unless:

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

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

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

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

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

23 (6) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may  
24 not rescind a small employer health benefit plan unless:

25 (a) The small employer or a representative of the small employer:

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

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

29 (b) The carrier provides at least 30 days' advance written notice, in the form and manner pre-  
30 scribed by the department, to each plan enrollee who would be affected by the rescission of cover-  
31 age; and

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

34 (7)(a) A carrier may continue to enforce reasonable employer participation and contribution re-  
35 quirements on small employers. However, participation and contribution requirements shall be ap-  
36 plied uniformly among all small employer groups with the same number of eligible employees  
37 applying for coverage or receiving coverage from the carrier. In determining minimum participation  
38 requirements, a carrier shall count only those employees who are not covered by an existing group  
39 health benefit plan, Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored  
40 or subsidized health plan, including but not limited to the medical assistance program under ORS  
41 chapter 414.

42 (b) A carrier may not deny a small employer's application for coverage under a health benefit  
43 plan based on participation or contribution requirements but may require small employers that do  
44 not meet participation or contribution requirements to enroll during the open enrollment period  
45 beginning November 15 and ending December 15.

1 (8) Premium rates for small employer health benefit plans, **except grandfathered health plans**,  
2 shall be subject to the following provisions:

3 (a) Each carrier must file with the department the initial geographic average rate and any  
4 changes in the geographic average rate with respect to each health benefit plan issued by the car-  
5 rier to small employers.

6 (b)(A) The variations in premium rates charged during a rating period for health benefit plans  
7 issued to small employers shall be based solely on the factors specified in subparagraph (B) of this  
8 paragraph. A carrier may elect which of the factors specified in subparagraph (B) of this paragraph  
9 apply to premium rates for health benefit plans for small employers. All other factors must be ap-  
10 plied in the same actuarially sound way to all small employer health benefit plans.

11 (B) The variations in premium rates described in subparagraph (A) of this paragraph may be  
12 based only on one or more of the following factors as prescribed by the department by rule:

13 (i) The ages of enrolled employees and their dependents, except that the rate for adults may not  
14 vary by more than three to one;

15 (ii) The level at which enrolled employees and their dependents 18 years of age and older engage  
16 in tobacco use, except that the rate may not vary by more than 1.5 to one; and

17 (iii) Adjustments to reflect differences in family composition.

18 (C) A carrier shall apply the carrier's schedule of premium rate variations as approved by the  
19 department and in accordance with this paragraph. Except as otherwise provided in this section, the  
20 premium rate established by a carrier for a small employer health benefit plan shall apply uniformly  
21 to all employees of the small employer enrolled in that plan.

22 (c) Except as provided in paragraph (b) of this subsection, the variation in premium rates be-  
23 tween different health benefit plans offered by a carrier to small employers must be based solely on  
24 objective differences in plan design or coverage, age, tobacco use and family composition and must  
25 not include differences based on the risk characteristics of groups assumed to select a particular  
26 health benefit plan.

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

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

33 (B) Any adjustment attributable to changes in age and differences in family composition.

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

36 **(9) Premium rates for grandfathered health plans shall be subject to requirements pre-**  
37 **scribed by the department by rule.**

38 *[(9)]* **(10)** In connection with the offering for sale of any health benefit plan to a small employer,  
39 each carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

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

41 (b) The authority of the carrier to adjust rates and premiums, and the extent to which the car-  
42 rier *[will consider]* **considers** age, tobacco use, family composition and geographic factors in estab-  
43 lishing and adjusting rates and premiums; and

44 (c) The benefits and premiums for all health insurance coverage for which the employer is  
45 qualified.

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

6 (b) A carrier offering a small employer health benefit plan shall file with the department at least  
7 once every 12 months an actuarial certification that the carrier is in compliance with ORS 743.733  
8 to 743.737 and that the rating methods of the carrier are actuarially sound. Each certification shall  
9 be in a uniform form and manner and shall contain such information as specified by the department.  
10 A copy of each certification shall be retained by the carrier at its principal place of business. A  
11 carrier is not required to file the actuarial certification under this paragraph if the department has  
12 approved the carrier's rate filing within the preceding 12-month period.

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

18 [(11)] (12) A carrier shall not provide any financial or other incentive to any insurance producer  
19 that would encourage the insurance producer to [market and] sell health benefit plans of the carrier  
20 to small employer groups based on a small employer group's anticipated claims experience.

21 [(12)] (13) For purposes of this section, the date a small employer health benefit plan is contin-  
22 ued shall be the anniversary date of the first issuance of the health benefit plan.

23 [(13)] (14) A carrier must include a provision that offers coverage to all eligible employees of a  
24 small employer and to all dependents of the eligible employees to the extent the employer chooses  
25 to offer coverage to dependents.

26 [(14)] (15) All small employer health benefit plans shall contain special enrollment periods dur-  
27 ing which eligible employees and dependents may enroll for coverage, as provided by federal law  
28 and rules adopted by the department.

29 [(15)] (16) A small employer health benefit plan may not impose annual or lifetime limits on the  
30 dollar amount of essential health benefits.

31 [(16) *This section does not require a carrier to actively market, offer, issue or accept applications*  
32 *for a grandfathered health plan or from a small employer not eligible for coverage under such a*  
33 *plan.*]

34 **SECTION 15.** ORS 743.745 is amended to read:

35 743.745. (1) In order to ensure the broadest availability of small employer and individual health  
36 benefit plans, the Department of Consumer and Business Services may approve market conduct and  
37 other requirements for carriers and insurance producers, including:

38 (a) Registration by each carrier with the department of the carrier's intention to offer group  
39 health benefit plans under ORS 743.733 to 743.737 or individual health benefit plans, or both.

40 (b) To the extent deemed necessary by the department to ensure the fair distribution of high-risk  
41 individuals and groups among carriers, periodic reports by carriers and insurance producers con-  
42 cerning small employer and individual health benefit plans issued, provided that reporting require-  
43 ments shall be limited to information concerning case characteristics and numbers of health benefit  
44 plans in various categories [marketed] **sold** or issued to small employers and individuals.

45 (c) Methods concerning periodic demonstration by carriers offering health benefit plans to indi-

1 individuals or small employers and insurance producers that the carriers and insurance producers are  
2 *[marketing]* **selling** or issuing health benefit plans in fulfillment of the purposes of ORS 743.730 to  
3 743.773.

4 (2) The department may require carriers and insurance producers offering health benefit plans  
5 to individuals or small employers to use the open and special enrollment periods prescribed by the  
6 department by rule.

7 *[(3) For small employer plans, the department may specify services for which carriers may impose  
8 an exclusion period, the duration of the allowable exclusion period for each specified service and the  
9 manner in which credit will be given for exclusion periods imposed pursuant to prior health insurance  
10 coverage.]*

11 **NOTE:** Sections 16 and 17 were deleted by amendment. Subsequent sections were not renum-  
12 bered.

13 **SECTION 18.** ORS 743.751 is amended to read:

14 743.751. *[(1) Except for an individual grandfathered health plan, a carrier may require an applicant  
15 for individual or small group health benefit plan coverage to provide health-related information only  
16 for the purpose of health care management and may not use the information to deny coverage.]*

17 *[(2) Except for an individual grandfathered health plan, if a carrier requires an applicant to pro-  
18 vide health-related information, the carrier must also notify the applicant, in the form and manner  
19 prescribed by the Department of Consumer and Business Services, that the information may not be used  
20 to deny coverage.]*

21 **(1) Except as provided in subsection (2) of this section, a carrier may not:**

22 **(a) Require an applicant to provide health-related information as a precondition for the**  
23 **issuance of an individual health benefit plan policy; or**

24 **(b) Deny coverage under an individual health benefit plan policy based on health-related**  
25 **information provided by the applicant.**

26 **(2) A carrier may require an applicant for an individual grandfathered health plan to**  
27 **complete the standard health statement prescribed by the Department of Consumer and**  
28 **Business Services prior to enrollment for the purpose of:**

29 **(a) Determining eligibility for coverage; or**

30 **(b) Imposing a preexisting condition provision.**

31 **(3) A carrier may require an enrollee in a health benefit plan to complete the standard**  
32 **health statement prescribed by the department for the purpose of:**

33 **(a) Managing the enrollee's health care; or**

34 **(b) Administering:**

35 **(A) A program of health promotion or disease prevention, as described in 42 U.S.C.**  
36 **300gg-4;**

37 **(B) A program to promote healthy behaviors under ORS 743.824; or**

38 **(C) A wellness program defined by the department by rule.**

39 **SECTION 19.** ORS 743.754 is amended to read:

40 743.754. The following requirements apply to all group health benefit plans other than small  
41 employer health benefit plans covering two or more certificate holders:

42 (1) *[Except in the case of a late enrollee and except as otherwise provided in this section,]* A carrier  
43 offering a group health benefit plan may not decline to offer coverage to any eligible prospective  
44 enrollee and may not impose different terms or conditions on the coverage, premiums or contribu-  
45 tions of any enrollee in the group that are based on the actual or expected health status of the

1 enrollee.

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

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

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

8 *[(3) Late enrollees may be subjected to]*

9 (b) A group eligibility waiting period **for late enrollees** that does not exceed 90 days.

10 *[(4)]* (3) Each group health benefit plan shall contain a special enrollment period during which  
11 eligible employees and dependents may enroll for coverage, as provided by federal law and rules  
12 adopted by the Department of Consumer and Business Services.

13 (4)(a) **A carrier shall issue to a group any of the carrier's group health benefit plans of-**  
14 **fered by the carrier for which the group is eligible, if the group applies for the plan, agrees**  
15 **to make the required premium payments and agrees to satisfy the other requirements of the**  
16 **plan.**

17 (b) **The department may waive the requirements of this subsection if the department**  
18 **finds that issuing a plan to a group or groups would endanger the carrier's ability to fulfill**  
19 **its contractual obligations or result in financial impairment of the carrier.**

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

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

23 (b) The policyholder or, with respect to coverage of individual enrollees, an enrollee or a rep-  
24 resentative of an enrollee engages in fraud or makes an intentional misrepresentation of a material  
25 fact as prohibited by the terms of the plan.

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

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

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

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

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

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

41 *[(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans is-*  
42 *sued by the carrier in the group market in this state or in the specified service area.]*

43 (f) The carrier discontinues **both** offering and renewing a group health benefit plan in a speci-  
44 fied service area within this state because of an inability to reach an agreement with the health  
45 care providers or organization 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 of the decision to the department and to all policyholders covered by the  
3 plan;

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

6 (C) Must offer in writing to each policyholder covered by the plan, all other group health benefit  
7 plans that the carrier offers in the specified service area. The carrier shall offer the plans at least  
8 90 days prior to discontinuation.

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

13 (h) The carrier discontinues [*renewing or*] **both** offering and renewing a grandfathered health  
14 plan for all groups in this state or in a specified service area within this state, other than a plan  
15 discontinued under paragraph (f) of this subsection.

16 (i) With respect to plans that are being discontinued under paragraph (g) or (h) of this sub-  
17 section, the carrier must:

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

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

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

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

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

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

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

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

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

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

38 (a) The enrollee:

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

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

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

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

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

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

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

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

7 (b) The carrier provides at least 30 days' advance written notice, in the form and manner pre-  
8 scribed by the department, to each plan enrollee who would be affected by the rescission of cover-  
9 age; and

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

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

17 *[(10)] (9)* A group health benefit plan may not impose annual or lifetime limits on the dollar  
18 amount of essential health benefits.

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

21 **SECTION 20.** ORS 743.766 is amended to read:

22 743.766. (1) With respect to coverage under an individual health benefit plan, a carrier[:]

23 *[(a)]* may not impose an individual coverage waiting period *[that exceeds 90 days]*.

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

26 *[(c)] (2)* With respect to individual coverage under a grandfathered health plan, a carrier  
27 *[may]:*

28 **(a) May impose an exclusion period for specified covered services applicable to all indi-**  
29 **viduals enrolling for the first time in the individual health benefit plan.**

30 **(b) May** not impose a preexisting condition exclusion unless the exclusion complies with the  
31 following requirements:

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

35 (B) The exclusion expires no later than six months after the individual's effective date of cov-  
36 erage.

37 *[(2)] (3)* If the carrier elects to restrict coverage as described in subsection (1) **or (2)** of this  
38 section, the carrier shall reduce the duration of the period during which the restriction is imposed  
39 by an amount equal to the individual's aggregate periods of creditable coverage if the most recent  
40 period of creditable coverage is ongoing or ended within 63 days after the effective date of coverage  
41 in the new individual health benefit plan. The crediting of prior coverage in accordance with this  
42 subsection shall be applied without regard to the specific benefits covered during the prior period.

43 *[(3)] (4)* An individual health benefit plan other than a grandfathered health plan must cover,  
44 at a minimum, all essential health benefits.

45 *[(4)] (5)* A carrier shall renew an individual health benefit plan, including a health benefit plan



1 issued through a bona fide association, unless:

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

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

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

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

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

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

17 [*(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans is-*  
18 *sued by the carrier in the individual market in this state or in the specified service area.*]

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

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

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

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

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

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

37 (g) With respect to plans that are being discontinued under paragraph (e) or (f) of this sub-  
38 section, the carrier must:

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

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

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

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

1 finding that the continuation of the coverage would:

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

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

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

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

11 [(5)] (6) A carrier may modify an individual health benefit plan at the time of coverage renewal.  
12 The modification is not a discontinuation of the plan under subsection [(4)(c)] (5)(c), (e) and (f) of  
13 this section.

14 [(6)] (7) Notwithstanding any other provision of this section, and subject to the provisions of  
15 ORS 743.894 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder  
16 or a representative of the policyholder:

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

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

20 [(7)] (8) A carrier that continues to offer coverage in the individual market in this state is not  
21 required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier  
22 elects to continue a plan that is closed to new individual policyholders instead of offering alterna-  
23 tive coverage in its other individual health benefit plans, the coverage for all existing policyholders  
24 in the closed plan is renewable in accordance with subsection [(4)] (5) of this section.

25 [(8)] (9) An individual health benefit plan may not impose annual or lifetime limits on the dollar  
26 amount of essential health benefits.

27 **(10) A grandfathered health plan may not impose lifetime limits on the dollar amount of**  
28 **essential health benefits.**

29 [(9)] (11) This section does not require a carrier to actively market, offer, issue or accept ap-  
30 plications for [*a grandfathered health plan or from an individual not eligible for coverage under such*  
31 *a plan*]:

32 **(a) A bona fide association health benefit plan from individuals who are not members of**  
33 **the bona fide association; or**

34 **(b) A grandfathered health plan from individuals who are not eligible for coverage under**  
35 **the plan.**

36 **SECTION 21.** ORS 743.766, as amended by section 20 of this 2015 Act, is amended to read:

37 743.766. (1) With respect to coverage under an individual health benefit plan, a carrier may not  
38 impose an individual coverage waiting period.

39 (2) With respect to individual coverage under a grandfathered health plan, a carrier:

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

42 (b) May not impose a preexisting condition exclusion unless the exclusion complies with the  
43 following requirements:

44 (A) The exclusion applies only to a condition for which medical advice, diagnosis, care or  
45 treatment was recommended or received during the six-month period immediately preceding the

1 individual's effective date of coverage.

2 (B) The exclusion expires no later than six months after the individual's effective date of cov-  
3 erage.

4 *[(3) If the carrier elects to restrict coverage as described in subsection (1) or (2) of this section, the*  
5 *carrier shall reduce the duration of the period during which the restriction is imposed by an amount*  
6 *equal to the individual's aggregate periods of creditable coverage if the most recent period of creditable*  
7 *coverage is ongoing or ended within 63 days after the effective date of coverage in the new individual*  
8 *health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied*  
9 *without regard to the specific benefits covered during the prior period.]*

10 [(4)] (3) An individual health benefit plan other than a grandfathered health plan must cover,  
11 at a minimum, all essential health benefits.

12 [(5)] (4) A carrier shall renew an individual health benefit plan, including a health benefit plan  
13 issued through a bona fide association, unless:

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

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

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

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

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

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

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

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

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

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

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

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

1 (g) With respect to plans that are being discontinued under paragraph (e) or (f) of this sub-  
2 section, the carrier must:

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

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

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

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

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

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

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

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

20 [(6)] (5) A carrier may modify an individual health benefit plan at the time of coverage renewal.  
21 The modification is not a discontinuation of the plan under subsection [(5)(c)] (4)(c), (e) and (f) of  
22 this section.

23 [(7)] (6) Notwithstanding any other provision of this section, and subject to the provisions of  
24 ORS 743.894 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder  
25 or a representative of the policyholder:

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

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

29 [(8)] (7) A carrier that continues to offer coverage in the individual market in this state is not  
30 required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier  
31 elects to continue a plan that is closed to new individual policyholders instead of offering alterna-  
32 tive coverage in its other individual health benefit plans, the coverage for all existing policyholders  
33 in the closed plan is renewable in accordance with subsection [(5)] (4) of this section.

34 [(9)] (8) An individual health benefit plan may not impose annual or lifetime limits on the dollar  
35 amount of essential health benefits.

36 [(10)] (9) A grandfathered health plan may not impose lifetime limits on the dollar amount of  
37 essential health benefits.

38 [(11)] (10) This section does not require a carrier to actively market, offer, issue or accept ap-  
39 plications for:

40 (a) A bona fide association health benefit plan from individuals who are not members of the bona  
41 fide association; or

42 (b) A grandfathered health plan from individuals who are not eligible for coverage under the  
43 plan.

44 **SECTION 22.** ORS 743.769 is amended to read:

45 743.769. (1) Each carrier shall actively market all individual health benefit plans sold by the

1 carrier that are not grandfathered health plans.

2 (2) Except as provided in subsection (3) of this section, no carrier or insurance producer shall,  
3 directly or indirectly, discourage an individual from filing an application for coverage because of the  
4 health status, claims experience, occupation or geographic location of the individual.

5 (3) Subsection (2) of this section does not apply with respect to information provided by a carrier  
6 to an individual regarding the established geographic service area or a restricted network provision  
7 of a carrier.

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

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

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

23 **SECTION 22a.** ORS 743.769, as amended by section 22 of this 2015 Act, is amended to read:

24 743.769. (1) Each carrier shall actively market all individual health benefit plans sold by the  
25 carrier that are not grandfathered health plans.

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

29 (3) Subsection (2) of this section does not apply with respect to information provided by a carrier  
30 to an individual regarding the established geographic service area or a restricted network provision  
31 of a carrier.

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

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

37 (6) A carrier that elects to discontinue offering all of its individual health benefit plans under  
38 ORS 743.766 [(5)(c)] (4)(c) or to discontinue both offering and renewing all such plans is prohibited  
39 from offering and renewing health benefit plans in the individual market in this state for a period  
40 of five years from the date of notice to the director pursuant to ORS 743.766 [(5)(c)] (4)(c) or, if such  
41 notice is not provided, from the date on which the director provides notice to the carrier that the  
42 director has determined that the carrier has effectively discontinued offering individual health ben-  
43 efit plans in this state. This subsection does not apply with respect to a health benefit plan discon-  
44 tinued in a specified service area by a carrier that covers services provided only by a particular  
45 organization of health care providers or only by health care providers who are under contract with

1 the carrier.

2 **SECTION 23.** ORS 743.818 is amended to read:

3 743.818. (1) A carrier offering a health benefit plan [*as defined in ORS 743.730*], **an insurer of-**  
4 **fering insurance against the risk of economic loss assumed under a less than fully insured**  
5 **employee health plan described in ORS 742.065** and a third party administrator licensed under  
6 ORS 744.702 shall annually submit to the Department of Consumer and Business Services, in a form  
7 and manner prescribed by the department, data concerning the number of covered lives of the car-  
8 rier, **insurer** or third party administrator, reported by line of business and by zip code.

9 (2) The department shall aggregate the data collected under subsection (1) of this section and  
10 may publish reports on the number of covered lives in Oregon, by line of business and by region.

11 **SECTION 24.** ORS 743.826 is amended to read:

12 743.826. A carrier may offer a catastrophic plan only [*through the exchange and only*] to an in-  
13 dividual who:

14 (1) Is under 30 years of age at the beginning of the plan year; or

15 (2) Is exempt from any state or federal penalties imposed for failing to maintain minimal essen-  
16 tial coverage during the plan year.

17 **SECTION 25.** ORS 743.911 is amended to read:

18 743.911. (1) Except as provided in this subsection, when a claim under a health benefit plan is  
19 submitted to an insurer by a provider on behalf of an enrollee, the insurer shall pay a clean claim  
20 or deny the claim not later than 30 days after the date on which the insurer receives the claim. If  
21 an insurer requires additional information before payment of a claim, not later than 30 days after  
22 the date on which the insurer receives the claim, the insurer shall notify the enrollee and the pro-  
23 vider in writing and give the enrollee and the provider an explanation of the additional information  
24 needed to process the claim. The insurer shall pay a clean claim or deny the claim not later than  
25 30 days after the date on which the insurer receives the additional information.

26 (2) A contract between an insurer and a provider may not include a provision governing pay-  
27 ment of claims that limits the rights and remedies available to a provider under this section and  
28 ORS 743.913 or has the effect of relieving either party of [*their*] **its** obligations under this section  
29 and ORS 743.913.

30 (3) An insurer shall establish a method of communicating to providers the procedures and in-  
31 formation necessary to complete claim forms. The procedures and information must be reasonably  
32 accessible to providers.

33 (4) This section does not create an assignment of payment to a provider.

34 (5) Each insurer shall report to the Director of the Department of Consumer and Business Ser-  
35 vices [*annually*] on its compliance under this section according to requirements established by the  
36 director.

37 (6) The director shall adopt by rule a definition of “clean claim” and shall consider the definition  
38 of “clean claim” used by the federal Department of Health and Human Services for the payment of  
39 Medicare claims.

40 **SECTION 26.** ORS 743A.141 is amended to read:

41 743A.141. (1) As used in this section, “hearing aid” means any nondisposable, wearable instru-  
42 ment or device designed to aid or compensate for impaired human hearing and any necessary ear  
43 mold, part, attachments or accessory for the instrument or device, except batteries and cords.

44 (2) A health benefit plan, as defined in ORS 743.730, shall provide payment, coverage or re-  
45 imbursement for one hearing aid per hearing impaired ear if:

1 (a) Prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed  
2 physician; and

3 (b) **Medically** necessary for the treatment of hearing loss in an enrollee in the plan who is:

4 (A) 18 years of age or younger; or

5 (B) 19 to 25 years of age and enrolled in a secondary school or an accredited educational in-  
6 stitution.

7 (3)(a) The maximum benefit amount required by this section is \$4,000 every 48 months, but a  
8 health benefit plan may offer a benefit that is more favorable to the enrollee. **An insurer shall**  
9 **adjust** the benefit amount [*shall be adjusted*] on January 1 of each year to reflect the increase since  
10 January 1, 2010, in the U.S. City Average Consumer Price Index for All Urban Consumers for  
11 medical care as published by the Bureau of Labor Statistics of the United States Department of  
12 Labor.

13 (b) [*A health benefit plan*] **An insurer** may not impose any financial or contractual penalty upon  
14 an audiologist if an enrollee elects to purchase a hearing aid priced higher than the benefit amount  
15 by paying the difference between the benefit amount and the price of the hearing aid.

16 (4) [*A health benefit plan may subject*] The payment, coverage or reimbursement required under  
17 this section **may be subject** to provisions of the **health benefit** plan that apply to other durable  
18 medical equipment benefits covered by the plan, including but not limited to provisions relating to  
19 deductibles, coinsurance and prior authorization.

20 (5) This section is exempt from ORS 743A.001.

21 **SECTION 27.** ORS 750.003 is amended to read:

22 750.003. The purpose of this section and ORS 750.005, 750.025 and 750.045 is to encourage and  
23 guarantee the development of health care service contractors by licensing and regulating their op-  
24 eration to [*insure*] **ensure** that they provide high quality health care services through state licensed  
25 organizations meeting reasonable standards as to administration, services and financial soundness.

26 **SECTION 28.** ORS 750.055, as amended by section 5, chapter 25, Oregon Laws 2014, and section  
27 80, chapter 45, Oregon Laws 2014, is amended to read:

28 750.055. (1) The following provisions of the Insurance Code apply to health care service con-  
29 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

30 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,  
31 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,  
32 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,  
33 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992[,] **and** 731.870 [*and 743.061*].

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

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

39 [(c)] (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and  
40 733.695 to 733.780.

41 [(d)] (e) ORS chapter 734.

42 (f) **ORS 735.600 to 735.650.**

43 [(e)] (g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to  
44 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, **743.061**, 743.100 to 743.109, 743.402, **743.417**,  
45 743.472, 743.492, 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529,

1 743.550 to 743.552, 743.560, **743.565**, 743.600 to 743.610, 743.650 to 743.656, [743.764,] **743.680 to**  
2 **743.689, 743.730 to 743.773, 743.777, 743.788, 743.790**, 743.804, 743.807, 743.808, 743.814 to 743.839,  
3 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894,  
4 743.911, 743.912, 743.913, 743.917, **743.923**, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036,  
5 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082,  
6 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144,  
7 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188,  
8 743A.190, 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, and section 2,  
9 chapter 25, Oregon Laws 2014.

10 [(f)] **(h)** The provisions of ORS chapter 744 relating to the regulation of insurance producers **and**  
11 **third party administrators.**

12 [(g)] **(i)** ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608,  
13 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and  
14 746.690.

15 [(h)] **(j)** ORS 743A.024, except in the case of group practice health maintenance organizations  
16 that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient  
17 is referred by a physician, physician assistant or nurse practitioner associated with a group practice  
18 health maintenance organization.

19 [(i) ORS 735.600 to 735.650.]

20 [(j) ORS 743.680 to 743.689.]

21 [(k) ORS 744.700 to 744.740.]

22 [(L) ORS 743.730 to 743.773.]

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

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

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

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

33 **SECTION 29.** ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section  
34 6, chapter 25, Oregon Laws 2014, and section 81, chapter 45, Oregon Laws 2014, is amended to read:

35 750.055. (1) The following provisions of the Insurance Code apply to health care service con-  
36 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

37 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,  
38 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,  
39 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,  
40 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992[,] **and** 731.870 [and 743.061].

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

44 [(b)] **(c)** ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592,  
45 not including ORS 732.582.



1       [(c)] (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and  
2 733.695 to 733.780.

3       [(d)] (e) ORS chapter 734.

4       **(f) ORS 735.600 to 735.650.**

5       [(e)] (g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to  
6 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, **743.061**, 743.100 to 743.109, 743.402, **743.417**,  
7 743.472, 743.492, 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529,  
8 743.550, 743.552, 743.560, **743.565**, 743.600 to 743.610, 743.650 to 743.656, [743.764,] **743.680 to 743.689**,  
9 **743.730 to 743.773, 743.777, 743.788, 743.790**, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.845,  
10 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911,  
11 743.912, 743.913, 743.917, **743.923**, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048,  
12 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084,  
13 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148,  
14 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190,  
15 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, and section 2, chapter 25,  
16 Oregon Laws 2014.

17       [(f)] (h) The provisions of ORS chapter 744 relating to the regulation of insurance producers **and**  
18 **third party administrators.**

19       [(g)] (i) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608,  
20 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and  
21 746.690.

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

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

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

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

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

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

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

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

39       **SECTION 30.** ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section  
40 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, and section 82, chapter  
41 45, Oregon Laws 2014, is amended to read:

42       750.055. (1) The following provisions of the Insurance Code apply to health care service con-  
43 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

44       (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,  
45 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,

1 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,  
2 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992[,] and 731.870 [and 743.061].

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

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

8 [(c)] (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and  
9 733.695 to 733.780.

10 [(d)] (e) ORS chapter 734.

11 **(f) ORS 735.600 to 735.650.**

12 [(e)] (g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to  
13 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, **743.061**, 743.100 to 743.109, 743.402, **743.417**,  
14 743.472, 743.492, 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529,  
15 743.550, 743.552, 743.560, **743.565**, 743.600 to 743.610, 743.650 to 743.656, [743.764,] **743.680 to 743.689**,  
16 **743.730 to 743.773, 743.777, 743.788, 743.790**, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.845,  
17 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911,  
18 743.912, 743.913, 743.917, **743.923**, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048,  
19 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084,  
20 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148,  
21 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190,  
22 743A.192 and 743A.250 and section 2, chapter 25, Oregon Laws 2014.

23 [(f)] (h) The provisions of ORS chapter 744 relating to the regulation of insurance producers **and**  
24 **third party administrators.**

25 [(g)] (i) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608,  
26 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and  
27 746.690.

28 [(h)] (j) ORS 743A.024, except in the case of group practice health maintenance organizations  
29 that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient  
30 is referred by a physician, physician assistant or nurse practitioner associated with a group practice  
31 health maintenance organization.

32 [(i) ORS 743.680 to 743.689.]

33 [(j) ORS 744.700 to 744.740.]

34 [(k) ORS 743.730 to 743.773.]

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

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

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

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

45 **SECTION 31. ORS 743.775 is repealed.**

1       **SECTION 32.** Section 2 of this 2015 Act is repealed on January 2, 2020.

2       **SECTION 33.** (1) The amendments to ORS 743.734, 743.736, 743.737, 743.751, 743.754, 750.003  
3 and 750.055 by sections 12 to 14, 18, 19 and 27 to 30 of this 2015 Act apply to:

4       (a) A health benefit plan issued or renewed on or after the effective date of this 2015 Act;  
5 and

6       (b) A health benefit plan that, according to its terms, would renew on or after the ef-  
7 fective date of this 2015 Act but is renewed prior to the effective date of this 2015 Act.

8       (2) The amendments to ORS 743.106 by section 5 of this 2015 Act apply to health benefit  
9 plans issued or renewed on or after January 1, 2017.

10       (3) The amendments to ORS 743.602, 743.730, 743.766, 743.769, 743.818 and 743A.141 and  
11 section 66, chapter 681, Oregon Laws 2013, by sections 7 to 10, 21, 22a, 23 and 26 of this 2015  
12 Act apply to:

13       (a) A health benefit plan issued or renewed on or after January 1, 2016; and

14       (b) A health benefit plan that, according to its terms, would renew on or after January  
15 1, 2016, but is renewed prior to January 1, 2016.

16       **SECTION 34.** The amendments to ORS 743.766 and 743.769 by sections 21 and 22a of this  
17 2015 Act become operative on January 1, 2016.

18       **SECTION 35.** This 2015 Act being necessary for the immediate preservation of the public  
19 peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect  
20 on its passage.

21