

# House Bill 2466

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 **as introduced**.

Modifies requirements for health benefit plans 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, 743.734, 743.736, 743.737, 743.751, 743.754, 743.766 and 743.769 and section 66,  
4 chapter 681, Oregon Laws 2013; and declaring an emergency.

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

6 **SECTION 1.** ORS 731.146 is amended to read:

7 731.146. (1) "Transact insurance" means one or more of the following acts effected by mail or  
8 otherwise:

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

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

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

13 (d) Issuing or delivering policies of insurance.

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

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

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

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

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

**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 Code.

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

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

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

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

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

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

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

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

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

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

24 **SECTION 2.** ORS 743.106 is amended to read:

25 743.106. (1) No policy form shall be delivered or issued for delivery in this state unless:

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

28 (b) The policy, except for specification pages, schedules and tables is printed in not less than  
29 **12-point type, 13-point leading for health benefit plans, as defined in ORS 743.730, and** 10-point  
30 type, [*one point leaded*] **11-point leading for all other policies;**

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

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

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

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

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

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

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

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

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

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

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

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

12 (A) The name and address of the insurer; the name, number or title of the policy; the table of  
 13 contents or index; captions and subcaptions; specification pages; schedules or tables; and

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

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

22 (4) Each policy filing shall be accompanied by a certificate signed by an officer of the insurer  
 23 stating that the policy meets the minimum required reading ease score on the test used, or stating  
 24 that the score is lower than the minimum required but should be authorized in accordance with ORS  
 25 743.107. To confirm the accuracy of a certification, the director may require the submission of fur-  
 26 ther information.

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

29 **SECTION 3.** ORS 743.552 is amended to read:

30 743.552. The Director of the Department of Consumer and Business Services shall by rule es-  
 31 tablish guidelines for the coordination of benefits for individual and [small] group health insurance,  
 32 including:

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

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

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

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

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

39 **SECTION 4.** ORS 743.602 is amended to read:

40 743.602. If a legally separated, divorced or surviving spouse elects continuation of coverage un-  
 41 der ORS 743.601 (1) to (6):

42 (1) The monthly premium for the continuation shall not be greater than the amount that would  
 43 be charged if the legally separated, divorced or surviving spouse were a current certificate holder  
 44 of the group plan plus the amount that the group policyholder would contribute toward the premium  
 45 if the legally separated, divorced or surviving spouse were a certificate holder of the group plan,

1 plus an additional amount not to exceed two percent of the certificate holder and group plan holder  
 2 contributions, for the costs of administration.

3 (2) The first premium shall be paid by the legally separated, divorced or surviving spouse within  
 4 45 days of the date of the election.

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

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

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

12 (c) The date on which the legally separated, divorced or surviving spouse becomes insured under  
 13 any other group health plan;

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

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

18 **SECTION 5.** ORS 743.730 is amended to read:

19 743.730. For purposes of ORS 743.730 to 743.773:

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

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

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

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

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

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

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

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

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

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

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

44 (d) Makes health insurance coverage that is offered through the association available to all  
 45 members of the association regardless of the health status of the member or individuals who are

1 eligible for coverage through the member;

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

4 (f) Has a constitution and bylaws; and

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

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

7 (a) A licensed insurance company;

8 (b) A health care service contractor;

9 (c) A health maintenance organization;

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

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

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

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

17 (6) "Catastrophic plan" means a health benefit plan that meets the requirements for a cat-  
18 astrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon health insurance  
19 exchange.

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

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

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

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

32 (11) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligi-  
33 ble for a group or individual health benefit plan who has enrolled for coverage under the terms of  
34 the plan.

35 (12) "Exchange" means the health insurance exchange administered by the Oregon Health In-  
36 surance Exchange Corporation in accordance with ORS 741.310.

37 (13) "Exclusion period" means a period during which specified treatments or services are ex-  
38 cluded from coverage.

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

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

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

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

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

1 (B) Individual health benefit plans.

2 (b) "Geographic average rate" does not include premium differences that are due to differences  
3 in benefit design, age, tobacco use or family composition.

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

6 (17) "Group eligibility waiting period" means, with respect to a group health benefit plan, the  
7 period of employment or membership with the group that a prospective enrollee must complete be-  
8 fore plan coverage begins.

9 (18)(a) "Health benefit plan" means any:

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

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

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

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

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

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

18 (C) Medicare supplement insurance policies;

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

20 (E) Benefits delivered through a flexible spending arrangement established pursuant to section  
21 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition  
22 to a group health benefit plan;

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

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

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

29 (I) Dental only coverage;

30 (J) Vision only coverage;

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

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

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

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

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

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

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

44 (20) "Individual health benefit plan" means a health benefit plan:

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

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

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

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

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

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

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

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

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

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

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

25 (25) "Preexisting condition exclusion" means:

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

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

36 (26) "Premium" includes insurance premiums or other fees charged for a health benefit plan,  
 37 including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by  
 38 the plan.

39 (27) "Rating period" means the 12-month calendar period for which premium rates established  
 40 by a carrier are in effect, as determined by the carrier.

41 (28) "Representative" does not include an insurance producer or an employee or authorized  
 42 representative of an insurance producer or carrier.

43 (29)(a) "Small employer" means:

44 (A) An employer, or a predecessor of the employer, that employed an average of at least one  
 45 but not more than 50 employees on business days during the [preceding] calendar year preceding

1 **the first day of the plan year**, the majority of whom are employed within this state, and that em-  
 2 ploys at least one [*eligible*] **full-time or full-time equivalent** employee on the first day of the plan  
 3 year; **or**

4 **(B) An employer that was not in existence, and for which there was no predecessor em-**  
 5 **ployer in existence, throughout the calendar year preceding the first day of the plan year and**  
 6 **that is reasonably expected to employ an average of at least one but not more than 50 em-**  
 7 **ployees during the current calendar year.**

8 **(b) An employer described in paragraph (a) of this subsection that enrolls its employees**  
 9 **in qualified health plans through the health insurance exchange under ORS 741.310, and that**  
 10 **subsequently employs an average of more than 50 employees, continues to be a small em-**  
 11 **ployer during the time that the employer enrolls its employees in qualified health plans**  
 12 **through the health insurance exchange.**

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

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

18 **SECTION 6.** ORS 743.730, as amended by section 59, chapter 681, Oregon Laws 2013, is  
 19 amended to read:

20 743.730. For purposes of ORS 743.730 to 743.773:

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

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

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

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

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

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

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

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

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

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

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

45 (d) Makes health insurance coverage that is offered through the association available to all



1 members of the association regardless of the health status of the member or individuals who are  
 2 eligible for coverage through the member;

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

5 (f) Has a constitution and bylaws; and

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

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

8 (a) A licensed insurance company;

9 (b) A health care service contractor;

10 (c) A health maintenance organization;

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

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

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

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

18 (6) "Catastrophic plan" means a health benefit plan that meets the requirements for a cat-  
 19 astrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon health insurance  
 20 exchange.

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

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

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

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

33 (11) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligi-  
 34 ble for a group or individual health benefit plan who has enrolled for coverage under the terms of  
 35 the plan.

36 (12) "Exchange" means the health insurance exchange administered by the Oregon Health In-  
 37 surance Exchange Corporation in accordance with ORS 741.310.

38 (13) "Exclusion period" means a period during which specified treatments or services are ex-  
 39 cluded from coverage.

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

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

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

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

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

2 (B) Individual health benefit plans.

3 (b) "Geographic average rate" does not include premium differences that are due to differences  
4 in benefit design, age, tobacco use or family composition.

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

7 (17) "Group eligibility waiting period" means, with respect to a group health benefit plan, the  
8 period of employment or membership with the group that a prospective enrollee must complete be-  
9 fore plan coverage begins.

10 (18)(a) "Health benefit plan" means any:

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

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

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

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

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

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

19 (C) Medicare supplement insurance policies;

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

21 (E) Benefits delivered through a flexible spending arrangement established pursuant to section  
22 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition  
23 to a group health benefit plan;

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

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

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

30 (I) Dental only coverage;

31 (J) Vision only coverage;

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

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

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

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

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

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

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

45 (20) "Individual health benefit plan" means a health benefit plan:

- 1 (a) That is issued to an individual policyholder; or
- 2 (b) That provides individual coverage through a trust, association or similar group, regardless
- 3 of the situs of the policy or contract.
- 4 (21) "Initial enrollment period" means a period of at least 30 days following commencement of
- 5 the first eligibility period for an individual.
- 6 (22) "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent
- 7 to the initial enrollment period during which the individual was eligible for coverage but declined
- 8 to enroll. However, an eligible individual shall not be considered a late enrollee if:
- 9 (a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg
- 10 or as prescribed by rule by the Department of Consumer and Business Services;
- 11 (b) The individual applies for coverage during an open enrollment period;
- 12 (c) A court issues an order that coverage be provided for a spouse or minor child under an
- 13 employee's employer sponsored health benefit plan and request for enrollment is made within 30
- 14 days after issuance of the court order;
- 15 (d) The individual is employed by an employer that offers multiple health benefit plans and the
- 16 individual elects a different health benefit plan during an open enrollment period; or
- 17 (e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a
- 18 publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance
- 19 program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for
- 20 coverage in a group health benefit plan.
- 21 (23) "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the
- 22 Internal Revenue Code.
- 23 (24) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement
- 24 as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended,
- 25 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.
- 26 (25) "Preexisting condition exclusion" means:
- 27 (a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of
- 28 coverage based on a medical condition being present before the effective date of coverage or before
- 29 the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was
- 30 recommended or received for the condition before the date of coverage or denial of coverage.
- 31 (b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late
- 32 enrollee that excludes coverage for services, charges or expenses incurred during a specified period
- 33 immediately following enrollment for a condition for which medical advice, diagnosis, care or treat-
- 34 ment was recommended or received during a specified period immediately preceding enrollment. For
- 35 purposes of this paragraph pregnancy and genetic information do not constitute preexisting condi-
- 36 tions.
- 37 (26) "Premium" includes insurance premiums or other fees charged for a health benefit plan,
- 38 including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by
- 39 the plan.
- 40 (27) "Rating period" means the 12-month calendar period for which premium rates established
- 41 by a carrier are in effect, as determined by the carrier.
- 42 (28) "Representative" does not include an insurance producer or an employee or authorized
- 43 representative of an insurance producer or carrier.
- 44 (29)(a) "Small employer" means:
- 45 **(A) An employer, or a predecessor of the employer,** that employed an average of at least one

1 but not more than 100 employees on business days during the [*preceding*] calendar year **preceding**  
 2 **the first day of the plan year**, the majority of whom are employed within this state, and that em-  
 3 ploys at least one [*eligible*] **full-time or full-time equivalent** employee on the first day of the plan  
 4 year; **or**

5 **(B) An employer that was not in existence, and for which there was no predecessor em-**  
 6 **ployer in existence, throughout the calendar year preceding the first day of the plan year and**  
 7 **that is reasonably expected to employ an average of at least one but not more than 100 em-**  
 8 **ployees during the current calendar year.**

9 **(b) An employer described in paragraph (a) of this subsection that enrolls its employees**  
 10 **in qualified health plans through the health insurance exchange under ORS 741.310, and that**  
 11 **subsequently employs an average of more than 100 employees, continues to be a small em-**  
 12 **ployer during the time that the employer enrolls its employees in qualified health plans**  
 13 **through the health insurance exchange.**

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

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

19 **SECTION 7.** Section 66, chapter 681, Oregon Laws 2013, is amended to read:

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

22 (b) The amendments to ORS 743.730 by section 59, [*of this 2013 Act*] **chapter 681, Oregon Laws**  
 23 **2013,** become operative January [2] 1, 2016.

24 (2) The amendments to ORS 731.146, 743.734 and 743.822 by sections 9, 20 and 31, [*of this 2013*  
 25 *Act*] **chapter 681, Oregon Laws 2013,** become operative January 2, 2014.

26 **SECTION 8.** ORS 743.734 is amended to read:

27 743.734. (1) Every health benefit plan shall be subject to the provisions of ORS 743.733 to  
 28 743.737, if the plan provides health benefits covering one or more employees of a small employer and  
 29 if any one of the following conditions is met:

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

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

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

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

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

42 (3)(a) A carrier may provide different health benefit plans to different categories of employees  
 43 of a small employer when the employer has chosen to establish different categories of employees in  
 44 a manner that does not relate to the actual or expected health status of such employees or their  
 45 dependents. The categories must be based on bona fide employment-based classifications that are

1 consistent with the employer's usual business practice.

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

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

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

9 **SECTION 9.** ORS 743.736 is amended to read:

10 743.736. (1) As a condition of transacting business in the small employer health insurance mar-  
 11 ket in this state, a carrier shall offer small employers all of the carrier's health benefit plans, ap-  
 12 proved by the Department of Consumer and Business Services for use in the small employer market,  
 13 for which the small employer is eligible.

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

17 [(3)] (2) A carrier shall issue to a small employer any health benefit plan that is offered by the  
 18 carrier if the small employer applies for the plan and agrees to make the required premium pay-  
 19 ments and to satisfy the other provisions of the health benefit plan.

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

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

36 [(6)] (5) A carrier is not required to accept applications from and offer coverage pursuant to  
 37 subsection [(3)] (2) of this section if the department finds that acceptance of an application or ap-  
 38 plications would endanger the carrier's ability to fulfill its contractual obligations or result in fi-  
 39 nancial impairment of the carrier.

40 [(7)] (6) A carrier shall market fairly all health benefit plans that are offered by the carrier to  
 41 small employers in the geographical areas in which the carrier makes coverage available or provides  
 42 benefits.

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

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

1 service area;

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

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

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

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

21 [(10)] (9) A carrier that elects to discontinue offering all of its health benefit plans to small  
22 employers under ORS 743.737 (3)(e), elects to discontinue renewing all such plans or elects to dis-  
23 continue offering and renewing all such plans is prohibited from offering health benefit plans to  
24 small employers in this state for a period of five years from one of the following dates:

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

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

29 [(11)] (10) This section does not require a carrier to actively market[,] **or** offer[, *issue or accept*  
30 *applications for a grandfathered health plan or from a small employer not eligible for coverage under*  
31 *such a plan as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended*  
32 *by the Health Care and Education Reconciliation Act (P.L. 111-152).]:*

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

35 (b) **A grandfathered health plan to a small employer that is not eligible for coverage un-**  
36 **der the plan.**

37 **SECTION 10.** ORS 743.737 is amended to read:

38 743.737. (1) A health benefit plan issued to a small employer:

39 (a) Must cover essential health benefits consistent with 42 U.S.C. [300gg-11] **300gg-6.**

40 (b) May:

41 (A) Require an affiliation period that does not exceed two months for an enrollee or 90 days for  
42 a late enrollee;

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

45 or

- 1 (C) Not apply a preexisting condition exclusion to any enrollee.
- 2 (2) Late enrollees in a small employer health benefit plan may be subjected to a group eligibility  
3 waiting period that does not exceed 90 days.
- 4 (3) Each small employer health benefit plan shall be renewable with respect to all eligible  
5 enrollees at the option of the policyholder, small employer or contract holder unless:
- 6 (a) The policyholder, small employer or contract holder fails to pay the required premiums.
- 7 (b) The policyholder, small employer or contract holder or, with respect to coverage of individ-  
8 ual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an inten-  
9 tional misrepresentation of a material fact as prohibited by the terms of the plan.
- 10 (c) The number of enrollees covered under the plan is less than the number or percentage of  
11 enrollees required by participation requirements under the plan.
- 12 (d) The small employer fails to comply with the contribution requirements under the health  
13 benefit plan.
- 14 (e) The carrier discontinues offering or renewing, or offering and renewing, all of its small em-  
15 ployer health benefit plans in this state or in a specified service area within this state. In order to  
16 discontinue plans under this paragraph, the carrier:
- 17 (A) Must give notice of the decision to the Department of Consumer and Business Services and  
18 to all policyholders covered by the plans;
- 19 (B) May not cancel coverage under the plans for 180 days after the date of the notice required  
20 under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except  
21 as provided in subparagraph (C) of this paragraph, in a specified service area;
- 22 (C) May not cancel coverage under the plans for 90 days after the date of the notice required  
23 under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area  
24 because of an inability to reach an agreement with the health care providers or organization of  
25 health care providers to provide services under the plans within the service area; and
- 26 (D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans  
27 issued by the carrier in the small employer market in this state or in the specified service area.
- 28 (f) The carrier discontinues offering and renewing a small employer health benefit plan in a  
29 specified service area within this state because of an inability to reach an agreement with the health  
30 care providers or organization of health care providers to provide services under the plan within the  
31 service area. In order to discontinue a plan under this paragraph, the carrier:
- 32 (A) Must give notice to the department and to all policyholders covered by the plan;
- 33 (B) May not cancel coverage under the plan for 90 days after the date of the notice required  
34 under subparagraph (A) of this paragraph; and
- 35 (C) Must offer in writing to each small employer covered by the plan, all other small employer  
36 health benefit plans that the carrier offers to small employers in the specified service area. The  
37 carrier shall issue any such plans pursuant to the provisions of ORS 743.733 to 743.737. The carrier  
38 shall offer the plans at least 90 days prior to discontinuation.
- 39 (g) The carrier discontinues offering or renewing, or offering and renewing, a health benefit  
40 plan, other than a grandfathered health plan, for all small employers in this state or in a specified  
41 service area within this state, other than a plan discontinued under paragraph (f) of this subsection.
- 42 (h) The carrier discontinues renewing or offering and renewing a grandfathered health plan for  
43 all small employers in this state or in a specified service area within this state, other than a plan  
44 discontinued under paragraph (f) of this subsection.
- 45 (i) With respect to plans that are being discontinued under paragraph (g) or (h) of this sub-

1 section, the carrier must:

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

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

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

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

8 (j) 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 enrollees; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

43 (7)(a) A carrier may continue to enforce reasonable employer participation and contribution re-  
44 quirements on small employers. However, participation and contribution requirements shall be ap-  
45 plied uniformly among all small employer groups with the same number of *[eligible]* employees



1 applying for coverage or receiving coverage from the carrier. In determining minimum participation  
2 requirements, a carrier shall count only those employees who are not covered by an existing group  
3 health benefit plan, Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored  
4 or subsidized health plan, including but not limited to the medical assistance program under ORS  
5 chapter 414.

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

10 (8) Premium rates for small employer health benefit plans shall be subject to the following pro-  
11 visions:

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

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

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

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

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

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

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

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

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

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

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

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

45 (9) In connection with the offering for sale of any health benefit plan to a small employer, each

1 carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

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

3 (b) The authority of the carrier to adjust rates and premiums, and the extent to which the carrier  
4 will consider age, tobacco use, family composition and geographic factors in establishing and  
5 adjusting rates and premiums; and

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

8 (10)(a) Each carrier shall maintain at its principal place of business a complete and detailed  
9 description of its rating practices and renewal underwriting practices relating to its small employer  
10 health benefit plans, including information and documentation that demonstrate that its rating  
11 methods and practices are based upon commonly accepted actuarial practices and are in accordance  
12 with sound actuarial principles.

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

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

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

28 (12) For purposes of this section, the date a small employer health benefit plan is continued shall  
29 be the anniversary date of the first issuance of the health benefit plan.

30 (13) A carrier must include a provision that offers coverage to all eligible employees of a small  
31 employer and to all dependents of the eligible employees to the extent the employer chooses to offer  
32 coverage to dependents.

33 (14) All small employer health benefit plans shall contain special enrollment periods during  
34 which eligible employees and dependents may enroll for coverage, as provided by federal law and  
35 rules adopted by the department.

36 (15) A small employer health benefit plan may not impose annual or lifetime limits on the dollar  
37 amount of essential health benefits.

38 (16) This section does not require a carrier to actively market[,], **or** offer[, *issue or accept appli-*  
39 *cations for a grandfathered health plan or from a small employer not eligible for coverage under such*  
40 *a plan.*]:

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

43 **(b) A grandfathered health plan to a small employer that is not eligible for coverage un-**  
44 **der the plan.**

45 **SECTION 11.** ORS 743.751 is amended to read:

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

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

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

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

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

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

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

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

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

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

21 **(b) Administering:**

22 **(A) A program of health promotion or disease prevention, as described in 42 U.S.C.**  
 23 **300gg-4;**

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

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

26 **SECTION 12.** ORS 743.754 is amended to read:

27 743.754. The following requirements apply to all group health benefit plans other than small  
 28 employer health benefit plans covering two or more certificate holders:

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

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

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

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

40 (3) Late enrollees may be subjected to a group eligibility waiting period that does not exceed  
 41 90 days.

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

45 (5) Each group health benefit plan shall be renewable with respect to all eligible enrollees at

1 the option of the policyholder unless:

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

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

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

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

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

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

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

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

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

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

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

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

31 (C) Must offer in writing to each policyholder covered by the plan, all other group health benefit  
32 plans that the carrier offers in the specified service area. The carrier shall offer the plans at least  
33 90 days prior to discontinuation.

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

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

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

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

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

45 (C) Act uniformly without regard to the claims experience of the affected policyholders or the

1 health status of any current or prospective enrollee.

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

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

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

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

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

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

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

17 (a) The enrollee:

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

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

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

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

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

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

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

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

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

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

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

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

43 (11) This section does not require a carrier to actively market[, ] **or** offer[, *issue or accept appli-*  
 44 *cations for a grandfathered health plan or from a group not eligible for coverage under such a plan.*]:

45 **(a) A bona fide association health benefit plan to individuals who are not members of the**

1 **bona fide association; or**

2 **(b) A grandfathered health plan to a small employer that is not eligible for coverage un-**  
 3 **der the plan.**

4 **SECTION 13.** ORS 743.766 is amended to read:

5 743.766. (1) With respect to coverage under an individual health benefit plan, a carrier:

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

7 (b) May impose an exclusion period **of no more than 90 days** for specified covered services  
 8 applicable to all individuals enrolling for the first time in the individual health benefit plan.

9 (c) With respect to individual coverage under a grandfathered health plan, a carrier may not  
 10 impose a preexisting condition exclusion unless the exclusion complies with the following require-  
 11 ments:

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

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

17 (2) If the carrier elects to restrict coverage as described in subsection (1) of this section, the  
 18 carrier shall reduce the duration of the period during which the restriction is imposed by an amount  
 19 equal to the individual's aggregate periods of creditable coverage if the most recent period of cred-  
 20 itable coverage is ongoing or ended within 63 days after the effective date of coverage in the new  
 21 individual health benefit plan. The crediting of prior coverage in accordance with this subsection  
 22 shall be applied without regard to the specific benefits covered during the prior period.

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

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

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

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

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

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

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

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

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

44 (d) The carrier discontinues offering and renewing an individual health benefit plan in a speci-  
 45 fied service area within this state because of an inability to reach an agreement with the health

1 care providers or organization of health care providers to provide services under the plan within the  
 2 service area. In order to discontinue a plan under this paragraph, the carrier:

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

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

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

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

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

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

18 (A) Offer in writing to each policyholder covered by the plan, all health benefit plans that the  
 19 carrier offers to individuals 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 (h) 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 enrollee; or

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

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

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

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

37 (6) Notwithstanding any other provision of this section, and subject to the provisions of ORS  
 38 743.894 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or a  
 39 representative of the policyholder:

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

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

43 (7) A carrier that continues to offer coverage in the individual market in this state is not re-  
 44 quired to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier  
 45 elects to continue a plan that is closed to new individual policyholders instead of offering alterna-

1 tive coverage in its other individual health benefit plans, the coverage for all existing policyholders  
 2 in the closed plan is renewable in accordance with subsection (4) of this section.

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

5 **(9) A grandfathered health plan may not impose lifetime limits on the dollar amount of**  
 6 **essential health benefits.**

7 [(9)] (10) This section does not require a carrier to actively market[,] or offer[, *issue or accept*  
 8 *applications for a grandfathered health plan or from an individual not eligible for coverage under such*  
 9 *a plan.*]:

10 (a) **A bona fide association health benefit plan to individuals who are not members of the**  
 11 **bona fide association; or**

12 (b) **A grandfathered health plan to a small employer that is not eligible for coverage un-**  
 13 **der the plan.**

14 **SECTION 14.** ORS 743.766, as amended by section 13 of this 2015 Act, is amended to read:

15 743.766. (1) With respect to coverage under an individual health benefit plan, a carrier:

16 (a) May not impose an individual coverage waiting period.

17 (b) May impose an exclusion period **of no more than 90 days** for specified covered services  
 18 applicable to all individuals enrolling for the first time in the individual health benefit plan.

19 (c) With respect to individual coverage under a grandfathered health plan, a carrier may not  
 20 impose a preexisting condition exclusion unless the exclusion complies with the following require-  
 21 ments:

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

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

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

33 [(3)] (2) An individual health benefit plan other than a grandfathered health plan must cover,  
 34 at a minimum, all essential health benefits.

35 [(4)] (3) A carrier shall renew an individual health benefit plan, including a health benefit plan  
 36 issued through a bona fide association, unless:

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

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

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

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

45 (B) May not cancel coverage under the plans for 180 days after the date of the notice required



1 under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except  
2 as provided in subparagraph (C) of this paragraph, in a specified service area;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

45 [(5)] (4) A carrier may modify an individual health benefit plan at the time of coverage renewal.

1 The modification is not a discontinuation of the plan under subsection [(4)(c)] (3)(c), (e) and (f) of  
2 this section.

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

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

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

9 [(7)] (6) A carrier that continues to offer coverage in the individual market in this state is not  
10 required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier  
11 elects to continue a plan that is closed to new individual policyholders instead of offering alterna-  
12 tive coverage in its other individual health benefit plans, the coverage for all existing policyholders  
13 in the closed plan is renewable in accordance with subsection [(4)] (3) of this section.

14 [(8)] (7) An individual health benefit plan may not impose annual or lifetime limits on the dollar  
15 amount of essential health benefits.

16 [(9)] (8) A grandfathered health plan may not impose lifetime limits on the dollar amount of es-  
17 sential health benefits.

18 [(10)] (9) This section does not require a carrier to actively market or offer:

19 (a) A bona fide association health benefit plan to individuals who are not members of the bona  
20 fide association; or

21 (b) A grandfathered health plan to a small employer that is not eligible for coverage under the  
22 plan.

23 **SECTION 15.** ORS 743.769 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 [(4)(c)] (3)(c) or to discontinue offering and renewing all such plans is prohibited from  
39 offering and renewing health benefit plans in the individual market in this state for a period of five  
40 years from the date of notice to the director pursuant to ORS 743.766 [(4)(c)] (3)(c) or, if such notice  
41 is not provided, from the date on which the director provides notice to the carrier that the director  
42 has determined that the carrier has effectively discontinued offering individual health benefit plans  
43 in this state. This subsection does not apply with respect to a health benefit plan discontinued in  
44 a specified service area by a carrier that covers services provided only by a particular organization  
45 of health care providers or only by health care providers who are under contract with the carrier.

1       **SECTION 16.** (1) The amendments to ORS 731.146, 743.552, 743.734, 743.736, 743.737,  
2 743.751, 743.754 and 743.766 by sections 1, 3 and 8 to 13 of this 2015 Act apply to:

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

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

7       (2) If a health benefit plan was issued prior to the effective date of this 2015 Act, the  
8 amendments to ORS 731.146, 743.552, 743.734, 743.736, 743.737, 743.751, 743.754 and 743.766 by  
9 sections 1, 3 and 8 to 13 of this 2015 Act apply beginning on the date the health benefit plan  
10 is renewed.

11       (3) The amendments to ORS 743.106, 743.602, 743.730, 743.766 and 743.769 and section 66,  
12 chapter 681, Oregon Laws 2013, by sections 2, 4 to 7, 14 and 15 of this 2015 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       (4) If a health benefit plan was issued after the effective date of this 2015 Act and prior  
17 to January 1, 2016, the amendments to ORS 743.106, 743.602, 743.730, 743.766 and 743.769 and  
18 section 66, chapter 681, Oregon Laws 2013, by sections 2, 4 to 7, 14 and 15 of this 2015 Act  
19 apply beginning on the date the health benefit plan is renewed.

20       **SECTION 17.** This 2015 Act being necessary for the immediate preservation of the public  
21 peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect  
22 on its passage.  
23