

**A-Engrossed**  
**House Bill 2468**

Ordered by the House March 27  
Including House Amendments dated March 27

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.

Specifies requirements for scope of insurer's network of providers. [*Prohibits insurer from using drug formulary that discriminates against enrollee on basis of health status.*]

**A BILL FOR AN ACT**

1  
2 Relating to health insurance; creating new provisions; and amending ORS 743.801, 743.804, 746.230,  
3 750.055 and 750.333.

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

5 **SECTION 1. Section 2 of this 2015 Act is added to and made a part of the Insurance Code.**

6 **SECTION 2. (1) An insurer offering a health benefit plan in this state that provides cov-**  
7 **erage to individuals or to small employers, as defined in ORS 743.730, through a specified**  
8 **network of health care providers shall:**

9 (a) **Contract with or employ a network of providers that is sufficient in number, ge-**  
10 **ographic distribution and types of providers to ensure that all covered services under the**  
11 **health benefit plan, including mental health and substance abuse treatment, are accessible**  
12 **to enrollees without unreasonable delay.**

13 (b)(A) **With respect to health benefit plans offered through the health insurance ex-**  
14 **change under ORS 741.310, contract with a sufficient number and geographic distribution of**  
15 **essential community providers, where available, to ensure reasonable and timely access to**  
16 **a broad range of essential community providers for low-income, medically underserved indi-**  
17 **viduals in the plan's service area in accordance with the network adequacy standards es-**  
18 **tablished by the Oregon Health Insurance Exchange Corporation;**

19 (B) **If the health benefit plan offered through the health insurance exchange offers a**  
20 **majority of the covered services through physicians employed by the insurer or through a**  
21 **single contracted medical group, have a sufficient number and geographic distribution of**  
22 **employed or contracted providers and hospital facilities to ensure reasonable and timely ac-**  
23 **cess for low-income, medically underserved enrollees in the plan's service area, in accord-**  
24 **ance with network adequacy standards adopted by the Oregon Health Insurance Exchange**  
25 **Corporation; or**

26 (C) **With respect to health benefit plans offered outside of the health insurance exchange,**  
27 **contract with or employ a network of providers that is sufficient in number, geographic**  
28 **distribution and types of providers to ensure access to care by enrollees who reside in lo-**

**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 cations within the health benefit plan's service area that are designated by the Health Re-  
2 sources and Services Administration of the United States Department of Health and Human  
3 Services as health professional shortage areas or low-income zip codes.

4 (c) Annually report to the Department of Consumer and Business Services, in the format  
5 prescribed by the department, the insurer's plan for ensuring that the network of providers  
6 for each health benefit plan meets the requirements of this section.

7 (2)(a) An insurer may not discriminate with respect to participation under a health ben-  
8 efit plan or coverage under the plan against any health care provider who is acting within  
9 the scope of the provider's license or certification in this state.

10 (b) This subsection does not require an insurer to contract with any health care provider  
11 who is willing to abide by the insurer's terms and conditions for participation established by  
12 the insurer.

13 (c) This subsection does not prevent an insurer from establishing varying reimbursement  
14 rates based on quality or performance measures.

15 (d) Rules adopted by the Department of Consumer and Business Services to implement  
16 this section shall be consistent with the provisions of 42 U.S.C. 300gg-5 and the rules adopted  
17 by the United States Department of Health and Human Services, the United States Depart-  
18 ment of the Treasury or the United States Department of Labor to carry out 42 U.S.C.  
19 300gg-5.

20 (3) The Department of Consumer and Business Services shall use one of the following  
21 methods in evaluating whether the network of providers available to enrollees in a health  
22 benefit plan meets the requirements of this section:

23 (a) An approach by which an insurer submits evidence that the insurer is complying with  
24 at least one of the factors prescribed by the department by rule from each of the following  
25 categories:

26 (A) Access to care consistent with the needs of the enrollees served by the network;

27 (B) Consumer satisfaction;

28 (C) Transparency; and

29 (D) Quality of care and cost containment; or

30 (b) A nationally recognized standard adopted by the department and adjusted, as neces-  
31 sary, to reflect the age demographics of the enrollees in the plan.

32 (4) This section does not require an insurer to contract with an essential community  
33 provider that refuses to accept the insurer's generally applicable payment rates for services  
34 covered by the plan.

35 (5) This section does not require an insurer to submit provider contracts to the depart-  
36 ment for review.

37 **SECTION 3.** ORS 743.801 is amended to read:

38 743.801. As used in this section and ORS 743.803, 743.804, 743.806, 743.807, 743.808, 743.811,  
39 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854,  
40 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913,  
41 743.917 and 743.918 **and section 2 of this 2015 Act:**

42 (1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a  
43 health care item or service, or an insurer's failure or refusal to provide or to make a payment in  
44 whole or in part for a health care item or service, that is based on the insurer's:

45 (a) Denial of eligibility for or termination of enrollment in a health benefit plan;

1 (b) Rescission or cancellation of a policy or certificate;

2 (c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury  
3 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or  
4 services;

5 (d) Determination that a health care item or service is experimental, investigational or not  
6 medically necessary, effective or appropriate; or

7 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active  
8 course of treatment for purposes of continuity of care under ORS 743.854.

9 (2) "Authorized representative" means an individual who by law or by the consent of a person  
10 may act on behalf of the person.

11 (3) "Enrollee" has the meaning given that term in ORS 743.730.

12 (4) **"Essential community provider" has the meaning given that term in rules adopted by**  
13 **the Department of Consumer and Business Services consistent with the description of the**  
14 **term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and**  
15 **Human Services, the United States Department of the Treasury or the United States De-**  
16 **partment of Labor to carry out 42 U.S.C. 18031.**

17 [(4)] (5) "Grievance" means:

18 (a) A communication from an enrollee or an authorized representative of an enrollee expressing  
19 dissatisfaction with an adverse benefit determination, without specifically declining any right to  
20 appeal or review, that is:

21 (A) In writing, for an internal appeal or an external review; or

22 (B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expe-  
23 dited external review; or

24 (b) A written complaint submitted by an enrollee or an authorized representative of an enrollee  
25 regarding the:

26 (A) Availability, delivery or quality of a health care service;

27 (B) Claims payment, handling or reimbursement for health care services and, unless the enrollee  
28 has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit  
29 determination; or

30 (C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

31 [(5)] (6) "Health benefit plan" has the meaning given that term in ORS 743.730.

32 [(6)] (7) "Independent practice association" means a corporation wholly owned by providers, or  
33 whose membership consists entirely of providers, formed for the sole purpose of contracting with  
34 insurers for the provision of health care services to enrollees, or with employers for the provision  
35 of health care services to employees, or with a group, as described in ORS 731.098, to provide health  
36 care services to group members.

37 [(7)] (8) "Insurer" includes a health care service contractor as defined in ORS 750.005.

38 [(8)] (9) "Internal appeal" means a review by an insurer of an adverse benefit determination  
39 made by the insurer.

40 [(9)] (10) "Managed health insurance" means any health benefit plan that:

41 (a) Requires an enrollee to use a specified network or networks of providers managed, owned,  
42 under contract with or employed by the insurer in order to receive benefits under the plan, except  
43 for emergency or other specified limited service; or

44 (b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service  
45 provision that allows an enrollee to use providers outside of the specified network or networks at

1 the option of the enrollee and receive a reduced level of benefits.

2 [(10)] (11) "Medical services contract" means a contract between an insurer and an independent  
3 practice association, between an insurer and a provider, between an independent practice associ-  
4 ation and a provider or organization of providers, between medical or mental health clinics, and  
5 between a medical or mental health clinic and a provider to provide medical or mental health ser-  
6 vices. "Medical services contract" does not include a contract of employment or a contract creating  
7 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other  
8 similar professional organizations permitted by statute.

9 [(11)(a)] (12)(a) "Preferred provider organization insurance" means any health benefit plan that:

10 (A) Specifies a preferred network of providers managed, owned or under contract with or em-  
11 ployed by an insurer;

12 (B) Does not require an enrollee to use the preferred network of providers in order to receive  
13 benefits under the plan; and

14 (C) Creates financial incentives for an enrollee to use the preferred network of providers by  
15 providing an increased level of benefits.

16 (b) "Preferred provider organization insurance" does not mean a health benefit plan that has  
17 as its sole financial incentive a hold harmless provision under which providers in the preferred  
18 network agree to accept as payment in full the maximum allowable amounts that are specified in  
19 the medical services contracts.

20 [(12)] (13) "Prior authorization" means a determination by an insurer prior to provision of ser-  
21 vices that the insurer will provide reimbursement for the services. "Prior authorization" does not  
22 include referral approval for evaluation and management services between providers.

23 [(13)] (14) "Provider" means a person licensed, certified or otherwise authorized or permitted  
24 by laws of this state to administer medical or mental health services in the ordinary course of  
25 business or practice of a profession.

26 [(14)] (15) "Utilization review" means a set of formal techniques used by an insurer or delegated  
27 by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness,  
28 efficacy or efficiency of health care services, procedures or settings.

29 **SECTION 4.** ORS 743.801, as amended by section 3, chapter 596, Oregon Laws 2013, is amended  
30 to read:

31 743.801. As used in this section and ORS 743.065, 743.803, 743.804, 743.806, 743.807, 743.808,  
32 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839,  
33 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912,  
34 743.913, 743.917 and 743.918 **and section 2 of this 2015 Act:**

35 (1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a  
36 health care item or service, or an insurer's failure or refusal to provide or to make a payment in  
37 whole or in part for a health care item or service, that is based on the insurer's:

38 (a) Denial of eligibility for or termination of enrollment in a health benefit plan;

39 (b) Rescission or cancellation of a policy or certificate;

40 (c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury  
41 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or  
42 services;

43 (d) Determination that a health care item or service is experimental, investigational or not  
44 medically necessary, effective or appropriate; or

45 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active

1 course of treatment for purposes of continuity of care under ORS 743.854.

2 (2) "Authorized representative" means an individual who by law or by the consent of a person  
3 may act on behalf of the person.

4 (3) "Enrollee" has the meaning given that term in ORS 743.730.

5 (4) **"Essential community provider" has the meaning given that term in rules adopted by**  
6 **the Department of Consumer and Business Services consistent with the description of the**  
7 **term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and**  
8 **Human Services, the United States Department of the Treasury or the United States De-**  
9 **partment of Labor to carry out 42 U.S.C. 18031.**

10 [(4)] (5) "Grievance" means:

11 (a) A communication from an enrollee or an authorized representative of an enrollee expressing  
12 dissatisfaction with an adverse benefit determination, without specifically declining any right to  
13 appeal or review, that is:

14 (A) In writing, for an internal appeal or an external review; or

15 (B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expe-  
16 dited external review; or

17 (b) A written complaint submitted by an enrollee or an authorized representative of an enrollee  
18 regarding the:

19 (A) Availability, delivery or quality of a health care service;

20 (B) Claims payment, handling or reimbursement for health care services and, unless the enrollee  
21 has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit  
22 determination; or

23 (C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

24 [(5)] (6) "Health benefit plan" has the meaning given that term in ORS 743.730.

25 [(6)] (7) "Independent practice association" means a corporation wholly owned by providers, or  
26 whose membership consists entirely of providers, formed for the sole purpose of contracting with  
27 insurers for the provision of health care services to enrollees, or with employers for the provision  
28 of health care services to employees, or with a group, as described in ORS 731.098, to provide health  
29 care services to group members.

30 [(7)] (8) "Insurer" includes a health care service contractor as defined in ORS 750.005.

31 [(8)] (9) "Internal appeal" means a review by an insurer of an adverse benefit determination  
32 made by the insurer.

33 [(9)] (10) "Managed health insurance" means any health benefit plan that:

34 (a) Requires an enrollee to use a specified network or networks of providers managed, owned,  
35 under contract with or employed by the insurer in order to receive benefits under the plan, except  
36 for emergency or other specified limited service; or

37 (b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service  
38 provision that allows an enrollee to use providers outside of the specified network or networks at  
39 the option of the enrollee and receive a reduced level of benefits.

40 [(10)] (11) "Medical services contract" means a contract between an insurer and an independent  
41 practice association, between an insurer and a provider, between an independent practice associ-  
42 ation and a provider or organization of providers, between medical or mental health clinics, and  
43 between a medical or mental health clinic and a provider to provide medical or mental health ser-  
44 vices. "Medical services contract" does not include a contract of employment or a contract creating  
45 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other

1 similar professional organizations permitted by statute.

2 [(11)(a)] (12)(a) “Preferred provider organization insurance” means any health benefit plan that:

3 (A) Specifies a preferred network of providers managed, owned or under contract with or em-  
4 ployed by an insurer;

5 (B) Does not require an enrollee to use the preferred network of providers in order to receive  
6 benefits under the plan; and

7 (C) Creates financial incentives for an enrollee to use the preferred network of providers by  
8 providing an increased level of benefits.

9 (b) “Preferred provider organization insurance” does not mean a health benefit plan that has  
10 as its sole financial incentive a hold harmless provision under which providers in the preferred  
11 network agree to accept as payment in full the maximum allowable amounts that are specified in  
12 the medical services contracts.

13 [(12)] (13) “Prior authorization” means a determination by an insurer prior to provision of ser-  
14 vices that the insurer will provide reimbursement for the services. “Prior authorization” does not  
15 include referral approval for evaluation and management services between providers.

16 [(13)] (14) “Provider” means a person licensed, certified or otherwise authorized or permitted  
17 by laws of this state to administer medical or mental health services in the ordinary course of  
18 business or practice of a profession.

19 [(14)] (15) “Utilization review” means a set of formal techniques used by an insurer or delegated  
20 by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness,  
21 efficacy or efficiency of health care services, procedures or settings.

22 **SECTION 5.** ORS 743.804 is amended to read:

23 743.804. All insurers offering a health benefit plan in this state shall:

24 (1) Provide to all enrollees directly or in the case of a group policy to the employer or other  
25 policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon re-  
26 quest, the following information:

27 (a) The insurer’s written policy on the rights of enrollees, including the right:

28 (A) To participate in decision making regarding the enrollee’s health care.

29 (B) To be treated with respect and with recognition of the enrollee’s dignity and need for pri-  
30 vacy.

31 (C) To have grievances handled in accordance with this section.

32 (D) To be provided with the information described in this section.

33 (b) An explanation of the procedures described in subsection (2) of this section for making cov-  
34 erage determinations and resolving grievances. The explanation must be culturally and linguistically  
35 appropriate, as prescribed by the department by rule, and must include:

36 (A) The procedures for requesting an expedited response to an internal appeal under subsection  
37 (2)(d) of this section or for requesting an expedited external review of an adverse benefit determi-  
38 nation;

39 (B) A statement that if an insurer does not comply with the decision of an independent review  
40 organization under ORS 743.862, the enrollee may sue the insurer under ORS 743.864;

41 (C) The procedure to obtain assistance available from the insurer, if any, and from the Depart-  
42 ment of Consumer and Business Services in filing grievances; and

43 (D) A description of the process for filing a complaint with the department.

44 (c) A summary of benefits and an explanation of coverage in a form and manner prescribed by  
45 the department by rule.

- 1 (d) A summary of the insurer's policies on prescription drugs, including:  
2 (A) Cost-sharing differentials;  
3 (B) Restrictions on coverage;  
4 (C) Prescription drug formularies;  
5 (D) Procedures by which a provider with prescribing authority may prescribe drugs not included  
6 on the formulary;  
7 (E) Procedures for the coverage of prescription drugs not included on the formulary; and  
8 (F) A summary of the criteria for determining whether a drug is experimental or investigational.  
9 (e) A list of network providers and how the enrollee can obtain current information about the  
10 availability of providers and how to access and schedule services with providers, including clinic  
11 and hospital networks. **The list must be available online and upon request in printed format.**  
12 (f) Notice of the enrollee's right to select a primary care provider and specialty care providers.  
13 (g) How to obtain referrals for specialty care in accordance with ORS 743.856.  
14 (h) Restrictions on services obtained outside of the insurer's network or service area.  
15 (i) The availability of continuity of care as required by ORS 743.854.  
16 (j) Procedures for accessing after-hours care and emergency services as required by ORS  
17 743A.012.  
18 (k) Cost-sharing requirements and other charges to enrollees.  
19 (L) Procedures, if any, for changing providers.  
20 (m) Procedures, if any, by which enrollees may participate in the development of the insurer's  
21 corporate policies.  
22 (n) A summary of how the insurer makes decisions regarding coverage and payment for treat-  
23 ment or services, including a general description of any prior authorization and utilization control  
24 requirements that affect coverage or payment.  
25 (o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other provid-  
26 ers.  
27 (p) A summary of the insurer's procedures for protecting the confidentiality of medical records  
28 and other enrollee information.  
29 (q) An explanation of assistance provided to non-English-speaking enrollees.  
30 (r) Notice of the information available from the department that is filed by insurers as required  
31 under ORS 743.807, 743.814 and 743.817.  
32 (2) Establish procedures for making coverage determinations and resolving grievances that pro-  
33 vide for all of the following:  
34 (a) Timely notice of adverse benefit determinations in a form and manner approved by the de-  
35 partment or prescribed by the department by rule.  
36 (b) A method for recording all grievances, including the nature of the grievance and significant  
37 action taken.  
38 (c) Written decisions meeting criteria established by the Director of the Department of Con-  
39 sumer and Business Services by rule.  
40 (d) An expedited response to a request for an internal appeal that accommodates the clinical  
41 urgency of the situation.  
42 (e) At least one but not more than two levels of internal appeal for group health benefit plans  
43 and one level of internal appeal for individual health benefit plans. If an insurer provides:  
44 (A) Two levels of internal appeal, a person who was involved in the consideration of the initial  
45 denial or the first level of internal appeal may not be involved in the second level of internal appeal;

1 and

2 (B) No more than one level of internal appeal, a person who was involved in the consideration  
3 of the initial denial may not be involved in the internal appeal.

4 (f)(A) An external review that meets the requirements of ORS 743.857, 743.859 and 743.861 and  
5 is conducted in a manner approved by the department or prescribed by the department by rule, after  
6 the enrollee has exhausted internal appeals or after the enrollee has been deemed to have exhausted  
7 internal appeals.

8 (B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to strictly  
9 comply with this section and federal requirements for internal appeals.

10 (g) The opportunity for the enrollee to receive continued coverage of an approved and ongoing  
11 course of treatment under the health benefit plan pending the conclusion of the internal appeal  
12 process.

13 (h) The opportunity for the enrollee or any authorized representative chosen by the enrollee to:

14 (A) Submit for consideration by the insurer any written comments, documents, records and other  
15 materials relating to the adverse benefit determination; and

16 (B) Receive from the insurer, upon request and free of charge, reasonable access to and copies  
17 of all documents, records and other information relevant to the adverse benefit determination.

18 (3) Establish procedures for notifying affected enrollees of:

19 (a) A change in or termination of any benefit; and

20 (b)(A) The termination of a primary care delivery office or site; and

21 (B) Assistance available to enrollees in selecting a new primary care delivery office or site.

22 (4) Provide the information described in subsection (2) of this section and ORS 743.859 at each  
23 level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an  
24 enrollee who files a grievance.

25 (5) Upon the request of an enrollee, applicant or prospective applicant, provide:

26 (a) The insurer's annual report on grievances and internal appeals submitted to the department  
27 under subsection (8) of this section.

28 (b) A description of the insurer's efforts, if any, to monitor and improve the quality of health  
29 services.

30 (c) Information about the insurer's procedures for credentialing network providers.

31 (6) Provide, upon the request of an enrollee, a written summary of information that the insurer  
32 may consider in its utilization review of a particular condition or disease, to the extent the insurer  
33 maintains such criteria. Nothing in this subsection requires an insurer to advise an enrollee how the  
34 insurer would cover or treat that particular enrollee's disease or condition. Utilization review cri-  
35 teria that are proprietary shall be subject to oral disclosure only.

36 (7) Maintain for a period of at least six years written records that document all grievances de-  
37 scribed in ORS 743.801 [(4)(a)] **(5)(a)** and make the written records available for examination by the  
38 department or by an enrollee or authorized representative of an enrollee with respect to a grievance  
39 made by the enrollee. The written records must include but are not limited to the following:

40 (a) Notices and claims associated with each grievance.

41 (b) A general description of the reason for the grievance.

42 (c) The date the grievance was received by the insurer.

43 (d) The date of the internal appeal or the date of any internal appeal meeting held concerning  
44 the appeal.

45 (e) The result of the internal appeal at each level of appeal.



1 (f) The name of the covered person for whom the grievance was submitted.

2 (8) Provide an annual summary to the department of the insurer's aggregate data regarding  
3 grievances, internal appeals and requests for external review in a format prescribed by the depart-  
4 ment to ensure consistent reporting on the number, nature and disposition of grievances, internal  
5 appeals and requests for external review.

6 (9) Allow the exercise of any rights described in this section by an authorized representative.

7 **SECTION 6.** ORS 746.230, as amended by section 79, chapter 45, Oregon Laws 2014, is amended  
8 to read:

9 746.230. (1) No insurer or other person shall commit or perform any of the following unfair claim  
10 settlement practices:

11 (a) Misrepresenting facts or policy provisions in settling claims;

12 (b) Failing to acknowledge and act promptly upon communications relating to claims;

13 (c) Failing to adopt and implement reasonable standards for the prompt investigation of claims;

14 (d) Refusing to pay claims without conducting a reasonable investigation based on all available  
15 information;

16 (e) Failing to affirm or deny coverage of claims within a reasonable time after completed proof  
17 of loss statements have been submitted;

18 (f) Not attempting, in good faith, to promptly and equitably settle claims in which liability has  
19 become reasonably clear;

20 (g) Compelling claimants to initiate litigation to recover amounts due by offering substantially  
21 less than amounts ultimately recovered in actions brought by such claimants;

22 (h) Attempting to settle claims for less than the amount to which a reasonable person would  
23 believe a reasonable person was entitled after referring to written or printed advertising material  
24 accompanying or made part of an application;

25 (i) Attempting to settle claims on the basis of an application altered without notice to or consent  
26 of the applicant;

27 (j) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them,  
28 of the coverage under which payment has been made;

29 (k) Delaying investigation or payment of claims by requiring a claimant or the claimant's phy-  
30 sician, physician assistant or nurse practitioner to submit a preliminary claim report and then re-  
31 quiring subsequent submission of loss forms when both require essentially the same information;

32 (L) Failing to promptly settle claims under one coverage of a policy where liability has become  
33 reasonably clear in order to influence settlements under other coverages of the policy; or

34 (m) Failing to promptly provide the proper explanation of the basis relied on in the insurance  
35 policy in relation to the facts or applicable law for the denial of a claim.

36 (2) No insurer shall refuse, without just cause, to pay or settle claims arising under coverages  
37 provided by its policies with such frequency as to indicate a general business practice in this state,  
38 which general business practice is evidenced by:

39 (a) A substantial increase in the number of complaints against the insurer received by the De-  
40 partment of Consumer and Business Services;

41 (b) A substantial increase in the number of lawsuits filed against the insurer or its insureds by  
42 claimants; or

43 (c) Other relevant evidence.

44 [(3)(a) No health maintenance organization, as defined in ORS 750.005, shall unreasonably with-  
45 hold the granting of participating provider status from a class of statutorily authorized health care

1 *providers for services rendered within the lawful scope of practice if the health care providers are li-*  
2 *censed as such and reimbursement is for services mandated by statute.]*

3 *[(b) Any health maintenance organization that fails to comply with paragraph (a) of this subsection*  
4 *shall be subject to discipline under ORS 746.015.]*

5 *[(c) This subsection does not apply to group practice health maintenance organizations that are*  
6 *federally qualified pursuant to Title XIII of the Health Maintenance Organization Act.]*

7 **SECTION 7.** ORS 750.055, as amended by section 5, chapter 25, Oregon Laws 2014, and section  
8 80, chapter 45, Oregon Laws 2014, is amended to read:

9 750.055. (1) The following provisions of the Insurance Code apply to health care service con-  
10 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

11 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,  
12 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,  
13 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,  
14 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

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

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

19 (d) ORS chapter 734.

20 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to  
21 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,  
22 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550 to  
23 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to  
24 743.839, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864,  
25 743.894, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036,  
26 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082,  
27 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144,  
28 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188,  
29 743A.190, 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, and section 2,  
30 chapter 25, Oregon Laws 2014, **and section 2 of this 2015 Act.**

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

32 (g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,  
33 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

38 (i) ORS 735.600 to 735.650.

39 (j) ORS 743.680 to 743.689.

40 (k) ORS 744.700 to 744.740.

41 (L) ORS 743.730 to 743.773.

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

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

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

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

7 **SECTION 8.** ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section  
8 6, chapter 25, Oregon Laws 2014, and section 81, chapter 45, Oregon Laws 2014, is amended to read:

9 750.055. (1) The following provisions of the Insurance Code apply to health care service con-  
10 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

11 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,  
12 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,  
13 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,  
14 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

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

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

19 (d) ORS chapter 734.

20 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to  
21 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,  
22 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550, 743.552,  
23 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to 743.839,  
24 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894,  
25 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048,  
26 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084,  
27 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148,  
28 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190,  
29 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, and section 2, chapter 25,  
30 Oregon Laws 2014, **and section 2 of this 2015 Act.**

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

32 (g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,  
33 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

38 (i) ORS 743.680 to 743.689.

39 (j) ORS 744.700 to 744.740.

40 (k) ORS 743.730 to 743.773.

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

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

45 (3) Any for-profit health care service contractor organized under the laws of any other state that

1 is not governed by the insurance laws of the other state is subject to all requirements of ORS  
2 chapter 732.

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

6 **SECTION 9.** ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section  
7 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, and section 82, chapter  
8 45, Oregon Laws 2014, is amended to read:

9 750.055. (1) The following provisions of the Insurance Code apply to health care service con-  
10 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

11 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,  
12 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,  
13 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,  
14 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

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

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

19 (d) ORS chapter 734.

20 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to  
21 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,  
22 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550, 743.552,  
23 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to 743.839,  
24 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894,  
25 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048,  
26 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084,  
27 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148,  
28 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190,  
29 743A.192 and 743A.250 and section 2, chapter 25, Oregon Laws 2014, **and section 2 of this 2015**  
30 **Act.**

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

32 (g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,  
33 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

38 (i) ORS 743.680 to 743.689.

39 (j) ORS 744.700 to 744.740.

40 (k) ORS 743.730 to 743.773.

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

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

45 (3) Any for-profit health care service contractor organized under the laws of any other state that

1 is not governed by the insurance laws of the other state is subject to all requirements of ORS  
2 chapter 732.

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

6 **SECTION 10.** ORS 750.333, as amended by section 8, chapter 25, Oregon Laws 2014, is amended  
7 to read:

8 750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a mul-  
9 tiple employer welfare arrangement:

10 (a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,  
11 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,  
12 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 to 731.992 and 743.061.

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

14 (c) ORS chapter 734.

15 (d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

16 (e) ORS 743.028, 743.053, 743.499, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560,  
17 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.766 to 743.773), 743.801,  
18 743.804, 743.807, 743.808, 743.814 to 743.839, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858,  
19 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.912, 743.917, 743A.012, 743A.020, 743A.034,  
20 743A.052, 743A.064, 743A.065, 743A.080, 743A.082, 743A.100, 743A.104, 743A.110, 743A.144, 743A.150,  
21 743A.170, 743A.175, 743A.184, 743A.192 and 743A.250 and section 2, chapter 25, Oregon Laws 2014,  
22 **and section 2 of this 2015 Act.**

23 (f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048,  
24 743A.058, 743A.066, 743A.068, 743A.070, 743A.084, 743A.088, 743A.090, 743A.105, 743A.140, 743A.141,  
25 743A.148, 743A.168, 743A.180, 743A.185, 743A.188 and 743A.190. Multiple employer welfare arrange-  
26 ments to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this para-  
27 graph only as provided in ORS 743.730 to 743.773.

28 (g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insur-  
29 ance consultants, and ORS 744.700 to 744.740.

30 (h) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

31 (i) ORS 731.592 and 731.594.

32 (j) ORS 731.870.

33 (2) For the purposes of this section:

34 (a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

35 (b) References to certificates of authority shall be considered references to certificates of mul-  
36 tiple employer welfare arrangement.

37 (c) Contributions shall be considered premiums.

38 (3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the  
39 transaction of health insurance.

40 **SECTION 11. (1) Section 2 of this 2015 Act and the amendments to ORS 743.801, 743.804,**  
41 **746.230, 750.055 and 750.333 by sections 3 to 10 of this 2015 Act become operative on January**  
42 **1, 2017.**

43 **(2) Section 2 of this 2015 Act and the amendments to ORS 743.801, 743.804, 746.230, 750.055**  
44 **and 750.333 by sections 3 to 10 of this 2015 Act apply to a health benefit plan that is in effect**  
45 **on or after January 1, 2017.**

1        **SECTION 12.** The Department of Consumer and Business Services may take any action  
2 before the operative date specified in section 11 of this 2015 Act that is necessary to enable  
3 the department to enforce the requirements of section 2 of this 2015 Act and the amend-  
4 ments to ORS 743.801, 743.804, 746.230, 750.055 and 750.333 by sections 3 to 10 of this 2015 Act  
5 on and after the operative date specified in section 11 of this 2015 Act.  
6

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