House Bill 2468

Introduced and printed pursuant to House Rule 12.00. Presession 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.**

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.

1 **A BILL FOR AN ACT**

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

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

5 **SECTION 1. Sections 2 and 3 of this 2015 Act are added to and made a part of the In-**
6 **surance Code.**

7 **SECTION 2. (1) An insurer offering a health benefit plan in this state that provides cov-**
8 **erage through a specified 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, including**
11 **mental health and substance abuse treatment, are accessible to enrollees without unreason-**
12 **able 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 that enrollees in the plan have access to cul-**
29 **turally and linguistically appropriate health care services.**

30 **(c) Annually report to the Department of Consumer and Business Services, in the format**
31 **prescribed by the department, the insurer's plan for ensuring that the network of providers**

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 **for each health benefit plan meets the requirements of this section.**
2 **(2)(a) An insurer may not discriminate with respect to participation under a health ben-**
3 **efit plan or coverage under the plan against any health care provider who is acting within**
4 **the scope of the provider's license or certification in this state.**
5 **(b) This subsection does not require an insurer to contract with any health care provider**
6 **who is willing to abide by the insurer's terms and conditions for participation established by**
7 **the insurer.**
8 **(c) This subsection does not prevent an insurer from establishing varying reimbursement**
9 **rates based on quality or performance measures.**
10 **(d) Rules adopted by the Department of Consumer and Business Services to implement**
11 **this section shall conform, as far as practicable and appropriate in this state, to 42 U.S.C.**
12 **300gg-5 and the rules adopted by the United States Department of Health and Human Ser-**
13 **vices, the United States Department of the Treasury or the United States Department of**
14 **Labor to carry out 42 U.S.C. 300gg-5.**
15 **(3) An insurer may not, in the design of the insurer's provider network, discriminate**
16 **against any enrollee on the basis of health status.**
17 **(4) The Department of Consumer and Business Services shall prescribe by rule standards**
18 **for evaluating whether the network of providers available to enrollees in a health benefit**
19 **plan meets the requirements of this section using:**
20 **(a) An approach by which an insurer may choose one factor from among a set of factors**
21 **prescribed by the department in each of the following categories:**
22 **(A) Access to care.**
23 **(B) Provider availability.**
24 **(C) Quality of care.**
25 **(D) Availability of information about which providers in the network are accepting new**
26 **patients.**
27 **(E) Affordability and cost containment.**
28 **(F) Provider capacity.**
29 **(G) Member satisfaction; or**
30 **(b) A nationally recognized standard adopted by the department by rule.**
31 **(5) This section does not require an insurer to contract with an essential community**
32 **provider that refuses to accept the insurer's generally applicable payment rates for services**
33 **covered by the plan.**
34 **(6)(a) The department may not require an insurer to file any portion of the insurer's**
35 **provider or network contracts with the department under ORS 742.003, 743.018 or 743.748.**
36 **(b) The department may require an insurer to disclose provider or network contracts in**
37 **accordance with ORS 731.296 in order for the department to carry out its duties and func-**
38 **tions.**
39 **SECTION 3. (1) As used in this section, "drug formulary" means a list of prescription**
40 **drugs that are covered by an insurer in a health benefit plan and the protocols required by**
41 **the insurer for a health care provider to follow in prescribing the drugs.**
42 **(2) An insurer may not restrict the coverage of prescription drugs using a drug**
43 **formulary that discriminates against any enrollee on the basis of the enrollee's health status.**
44 **SECTION 4.** ORS 743.801 is amended to read:
45 743.801. As used in this section and ORS 743.803, 743.804, 743.806, 743.807, 743.808, 743.811,

1 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854,
2 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913,
3 743.917 and 743.918 **and sections 2 and 3 of this 2015 Act**:
4 (1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a
5 health care item or service, or an insurer's failure or refusal to provide or to make a payment in
6 whole or in part for a health care item or service, that is based on the insurer's:
7 (a) Denial of eligibility for or termination of enrollment in a health benefit plan;
8 (b) Rescission or cancellation of a policy or certificate;
9 (c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury
10 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or
11 services;
12 (d) Determination that a health care item or service is experimental, investigational or not
13 medically necessary, effective or appropriate; or
14 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active
15 course of treatment for purposes of continuity of care under ORS 743.854.
16 (2) "Authorized representative" means an individual who by law or by the consent of a person
17 may act on behalf of the person.
18 (3) "Enrollee" has the meaning given that term in ORS 743.730.
19 **(4) "Essential community provider" means a provider that predominantly serves low-**
20 **income, medically underserved patients.**
21 [*(4)*] **(5)** "Grievance" means:
22 (a) A communication from an enrollee or an authorized representative of an enrollee expressing
23 dissatisfaction with an adverse benefit determination, without specifically declining any right to
24 appeal or review, that is:
25 (A) In writing, for an internal appeal or an external review; or
26 (B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expe-
27 dited external review; or
28 (b) A written complaint submitted by an enrollee or an authorized representative of an enrollee
29 regarding the:
30 (A) Availability, delivery or quality of a health care service;
31 (B) Claims payment, handling or reimbursement for health care services and, unless the enrollee
32 has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit
33 determination; or
34 (C) Matters pertaining to the contractual relationship between an enrollee and an insurer.
35 [*(5)*] **(6)** "Health benefit plan" has the meaning given that term in ORS 743.730.
36 [*(6)*] **(7)** "Independent practice association" means a corporation wholly owned by providers, or
37 whose membership consists entirely of providers, formed for the sole purpose of contracting with
38 insurers for the provision of health care services to enrollees, or with employers for the provision
39 of health care services to employees, or with a group, as described in ORS 731.098, to provide health
40 care services to group members.
41 [*(7)*] **(8)** "Insurer" includes a health care service contractor as defined in ORS 750.005.
42 [*(8)*] **(9)** "Internal appeal" means a review by an insurer of an adverse benefit determination
43 made by the insurer.
44 [*(9)*] **(10)** "Managed health insurance" means any health benefit plan that:
45 (a) Requires an enrollee to use a specified network or networks of providers managed, owned,

under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

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

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

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

(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

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

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

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

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

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

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

SECTION 5. ORS 743.801, as amended by section 3, chapter 596, Oregon Laws 2013, is amended to read:

743.801. As used in this section and ORS 743.065, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913, 743.917 and 743.918 **and sections 2 and 3 of this 2015 Act**:

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

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

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

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

services;

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

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

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

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

(4) "Essential community provider" means a provider that predominantly serves low-income, medically underserved patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[*(10)*] **(11)** "Medical services contract" means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. "Medical services contract" does not include a contract of employment or a contract creating

legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

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

(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

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

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

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

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

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

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

SECTION 6. ORS 743.804 is amended to read:

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

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

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

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

(B) To be treated with respect and with recognition of the enrollee's dignity and need for privacy.

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

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

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

(A) The procedures for requesting an expedited response to an internal appeal under subsection (2)(d) of this section or for requesting an expedited external review of an adverse benefit determination;

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

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

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

(c) A summary of benefits and an explanation of coverage in a form and manner prescribed by

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

denial or the first level of internal appeal may not be involved in the second level of internal appeal; and

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

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

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

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

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

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

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

(3) Establish procedures for notifying affected enrollees of:

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

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

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

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

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

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

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

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

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

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

(a) Notices and claims associated with each grievance.

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

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

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

1 (e) The result of the internal appeal at each level of appeal.
2 (f) The name of the covered person for whom the grievance was submitted.
3 (8) Provide an annual summary to the department of the insurer's aggregate data regarding
4 grievances, internal appeals and requests for external review in a format prescribed by the depart-
5 ment to ensure consistent reporting on the number, nature and disposition of grievances, internal
6 appeals and requests for external review.
7 (9) Allow the exercise of any rights described in this section by an authorized representative.
8 **SECTION 7.** ORS 750.055, as amended by section 5, chapter 25, Oregon Laws 2014, and section
9 80, chapter 45, Oregon Laws 2014, is amended to read:
10 750.055. (1) The following provisions of the Insurance Code apply to health care service con-
11 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:
12 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,
13 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,
14 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,
15 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.
16 (b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not
17 including ORS 732.582.
18 (c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
19 to 733.780.
20 (d) ORS chapter 734.
21 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to
22 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,
23 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550 to
24 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to
25 743.839, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864,
26 743.894, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036,
27 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082,
28 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144,
29 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188,
30 743A.190, 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, and section 2,
31 chapter 25, Oregon Laws 2014**, and sections 2 and 3 of this 2015 Act**.
32 (f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.
33 (g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
34 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.
35 (h) ORS 743A.024, except in the case of group practice health maintenance organizations that
36 are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is
37 referred by a physician, physician assistant or nurse practitioner associated with a group practice
38 health maintenance organization.
39 (i) ORS 735.600 to 735.650.
40 (j) ORS 743.680 to 743.689.
41 (k) ORS 744.700 to 744.740.
42 (L) ORS 743.730 to 743.773.
43 (m) ORS 731.485, except in the case of a group practice health maintenance organization that
44 is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns
45 and operates an in-house drug outlet.

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

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

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

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

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

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

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

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

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550, 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 743.839, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, and section 2, chapter 25, Oregon Laws 2014**, and sections 2 and 3 of this 2015 Act**.

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

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

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

(i) ORS 743.680 to 743.689.

(j) ORS 744.700 to 744.740.

(k) ORS 743.730 to 743.773.

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

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

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

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

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

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

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

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

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

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550, 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 743.839, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192 and 743A.250 and section 2, chapter 25, Oregon Laws 2014**, and sections 2 and 3 of this 2015 Act**.

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

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

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

(i) ORS 743.680 to 743.689.

(j) ORS 744.700 to 744.740.

(k) ORS 743.730 to 743.773.

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

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

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

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

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

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

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

(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.

(c) ORS chapter 734.

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

(e) ORS 743.028, 743.053, 743.499, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.766 to 743.773), 743.801, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.912, 743.917, 743A.012, 743A.020, 743A.034, 743A.052, 743A.064, 743A.065, 743A.080, 743A.082, 743A.100, 743A.104, 743A.110, 743A.144, 743A.150, 743A.170, 743A.175, 743A.184, 743A.192 and 743A.250 and section 2, chapter 25, Oregon Laws 2014**, and sections 2 and 3 of this 2015 Act**.

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

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

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

(i) ORS 731.592 and 731.594.

(j) ORS 731.870.

(2) For the purposes of this section:

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

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

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

SECTION 11. (1) Sections 2 and 3 of this 2015 Act and the amendments to ORS 743.801, 743.804, 750.055 and 750.333 by sections 4 to 10 of this 2015 Act become operative on January 1, 2017.

(2) Sections 2 and 3 of this 2015 Act and the amendments to ORS 743.801, 743.804, 750.055 and 750.333 by sections 4 to 10 of this 2015 Act apply to a health benefit plan that is in effect

on or after January 1, 2017.

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