

Hand Engrossed
Key STG
4-9-15
-4 amendment

House Bill 2758

Sponsored by Representative WILLIAMSON, Senator BURDICK (Presession filed.)

SUMMARY

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

Prohibits carrier or third party administrator from disclosing to persons, other than enrollee who receives sensitive services, information relating to sensitive services provided to enrollee. Requires carrier and third party administrator to adopt procedures for enrollee to request to have personal health information protected from disclosure to policyholder or certificate holder if enrollee fears that disclosure will result in harassment or abuse of enrollee or will undermine enrollee's ability to access health care.

A BILL FOR AN ACT

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

Relating to protected health information; creating new provisions; ~~and~~ amending ORS 743.801, 743.804, 746.607, 750.055 and 750.333. *and declaring an emergency*

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

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

~~SECTION 2. (1) As used in sections 2 and 3 of this 2015 Act:~~

- ~~(a) "Carrier" has the meaning given that term in ORS 743.730.~~
- ~~(b) "Communication" includes:~~
 - ~~(A) An explanation of benefits notice;~~
 - ~~(B) Information about an appointment, including a confirmation and a reminder;~~
 - ~~(C) A notice of an adverse benefit determination;~~
 - ~~(D) A carrier's or third party administrator's request for additional information regarding a claim;~~
 - ~~(E) A notice of a contested claim;~~
 - ~~(F) The name and address of a provider, a description of services provided and other visit information; and~~
 - ~~(G) Any written, oral or electronic communication from a carrier or a third party administrator to a policyholder, certificate holder or enrollee that contains personal health information.~~
- ~~(c) "Confidential communications request" means a request from an enrollee to a carrier or third party administrator that communications be sent directly to the enrollee at a specified mail or electronic mail address or specified telephone number designated by the enrollee and that the carrier or third party administrator refrain from sending communications concerning the enrollee to the policyholder or certificate holder.~~
- ~~(d) "Health benefit plan" has the meaning given that term in ORS 743.730.~~
- ~~(e) "Personal health information" means information or data created by or derived from a provider about an individual that relates to:~~
 - ~~(A) The past, present or future health condition of the individual;~~

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 (B) The provision of health care to the individual;
2 (C) A request for the provision of health care to the individual; or
3 (D) The cost of or payment for health care provided to the individual.
4 (f) "Sensitive services" includes those services prescribed by the Department of Con-
5 sumer and Business Services by rule, including, but not limited to, preventative services,
6 counseling, diagnosis and treatment related to:
7 (A) Sexual or reproductive health, including, but not limited to, family planning, mater-
8 nity, abortion, fertility, gender transition, sexually transmitted infections, HIV and AIDS;
9 (B) Substance use;
10 (C) Mental health; or
11 (D) Domestic or interpersonal violence.
12 (2) A carrier and a third party administrator doing business in this state:
13 (a) May not reveal in any communication to a policyholder or certificate holder personal
14 health information about sensitive services sought or received by an enrollee, other than the
15 policyholder or certificate holder, regardless of whether the enrollee has submitted a confi-
16 dential communications request, unless the enrollee has executed a written authorization for
17 disclosure of the information that:
18 (A) Is submitted to the carrier or third party administrator in hard copy or electron-
19 ically;
20 (B) Is executed by a signature that serves no purpose other than to execute the author-
21 ization;
22 (C) Is signed and dated by the enrollee or by a legal representative of the enrollee; and
23 (D) If applicable, specifies the uses and limitations on the release of the information.
24 (b) Shall send any communication regarding sensitive services sought or received by an
25 enrollee directly to the enrollee who sought or received the services.
26 (c) Shall permit any enrollee to submit a confidential communications request.
27 (d) Shall comply with a confidential communications request made by an enrollee if the
28 enrollee states that disclosure of all or part of a communication regarding the enrollee may
29 lead to harassment or abuse of the enrollee or may undermine the enrollee's ability to access
30 health care.
31 (e) Shall update an enrollee on the status of implementing a confidential communications
32 request upon the enrollee's inquiry.
33 (f) Shall notify all enrollees in a health benefit plan offered or administered by the carrier
34 or third party administrator about an enrollee's right under this section to make a confi-
35 dential communications request and the carrier's or third party administrator's duty under
36 this section to provide communications regarding sensitive services only to the enrollee who
37 sought or received the services.
38 (3) The procedure adopted by a carrier or third party administrator for enrollees to make
39 confidential communications requests:
40 (a) Must use the form described in subsection (5) of this section.
41 (b) May not require the enrollee to explain why the enrollee fears that disclosure may
42 lead to harassment or abuse or may undermine the enrollee's ability to access health care.
43 (c) Shall ensure that the confidential communications request remains in effect until the
44 enrollee revokes the request in writing or submits a new confidential communications re-
45 quest.

1 (d) Shall ensure that the confidential communications request is acted upon and imple-
2 mented by the carrier or third party administrator not later than seven days after receipt
3 of a request by electronic means or 14 days after receipt of a request in hard copy.

4 (e) Must include a carrier's or third party administrator's immediate acknowledgement
5 to an enrollee by mail, telephone or electronic means of receipt by the carrier or third party
6 administrator of a confidential communications request.

7 (f) May not require an enrollee to waive any right to limit disclosure under this section
8 as a condition of eligibility for or coverage under a health benefit plan.

9 (g) Must be easy to understand and to complete.

10 (4) A provider may make an arrangement with an enrollee for the enrollee to pay to the
11 provider any cost sharing required under the health benefit plan and shall communicate the
12 arrangement to the carrier or third party administrator.

13 (5) The Department of Consumer and Business Services shall develop and make available
14 to the public a standardized form for an enrollee to use to make a confidential communi-
15 cations request. The department shall encourage providers to clearly display the form and
16 make it available to patients. The form must, at a minimum, allow an enrollee to:

17 (a) Indicate whether communications should be withheld by the carrier or third party
18 administrator or should be redirected to a specified mail or electronic mail address or spec-
19 ified telephone number; and

20 (b) Designate a telephone number or mail or electronic mail address for the carrier or
21 third party administrator to contact the enrollee if additional information or clarification is
22 necessary to process the confidential communications request.

23 (6) The department shall work with carriers, third party administrators and other
24 stakeholders to develop effective systems to protect the confidentiality of personal health
25 information and to ensure that carriers and third party administrators communicate directly
26 with an enrollee regarding sensitive services sought or received by the enrollee.

27 SECTION 3. (1) The Department of Consumer and Business Services shall actively mon-
28 itor compliance with section 2 of this 2015 Act and shall collect, track and investigate com-
29 plaints regarding the disclosure of communications in violation of section 2 of this 2015 Act.

30 (2) The department may impose a civil penalty of up to \$25,000 on a carrier or third party
31 administrator that discloses an enrollee's personal health information in violation of section
32 2 of this 2015 Act and up to \$17,500 for each subsequent disclosure of that enrollee's personal
33 health information.

34 (3) In determining the amount of a civil penalty imposed under this section, the depart-
35 ment shall consider all relevant factors, including, but not limited to:

36 (a) The carrier's or third party administrator's history of compliance with section 2 of
37 this 2015 Act and with other state and federal laws; and

38 (b) The extent to which the carrier or third party administrator detected a violation of
39 section 2 of this 2015 Act, immediately corrected the violation and took steps to prevent vi-
40 olations from recurring.

40 a "SECTION 1. Section 2 of this 2015 Act is added to and made a part
40b of the Insurance Code.

40 1 **"SECTION 2. (1) As used in this section:**

2 **"(a) 'Carrier' has the meaning given that term in ORS 743.730.**

3 **"(b) 'Communication' includes:**

4 **"(A) An explanation of benefits notice;**

5 **"(B) Information about an appointment, including a confirmation
6 and a reminder;**

7 **"(C) A notice of an adverse benefit determination;**

8 **"(D) A carrier's or third party administrator's request for additional
9 information regarding a claim;**

10 **"(E) A notice of a contested claim;**

11 **"(F) The name and address of a provider, a description of services
12 provided and other visit information; and**

13 **"(G) Any written, oral or electronic communication from a carrier
14 or a third party administrator to a policyholder, certificate holder or
15 enrollee that contains personal health information.**

16 **"(c) 'Confidential communications request' means a request from
17 an enrollee to a carrier or third party administrator that communi-
18 cations be sent directly to the enrollee at a specified mail or electronic
19 mail address or specified telephone number designated by the enrollee
20 and that the carrier or third party administrator refrain from sending
21 communications concerning the enrollee to the policyholder or certifi-
22 cate holder.**

23 **"(d) 'Health benefit plan' has the meaning given that term in ORS
24 743.730.**

25 **"(e) 'Personal health information' means information or data cre-
26 ated by or derived from a provider about an individual that relates to:**

27 **"(A) The past, present or future health condition of the individual;**

28 **"(B) The provision of health care to the individual;**

29 **"(C) A request for the provision of health care to the individual; or**

30 **"(D) The cost of or payment for health care provided to the indi-
31 vidual.**

32 **"(2) A carrier and a third party administrator doing business in this
33 state:**

34 **"(a) Shall permit any enrollee to submit a confidential communi-
35 cations request.**

[3a]

401 (b) Shall comply with a confidential communications request made
2 by an enrollee if the enrollee states that disclosure of all or part of a
3 communication regarding the enrollee may lead to harassment or
4 abuse of the enrollee or may undermine the enrollee's ability to access
5 health care.

6 (c) Shall update an enrollee on the status of implementing a con-
7 fidential communications request upon the enrollee's inquiry.

8 (3) The procedure adopted by a carrier or third party administrator
9 for enrollees to make confidential communications requests:

10 (a) Must use the form described in subsection (5) of this section
11 and may also allow enrollees to make the request by other means such
12 as telephone or online.

13 (b) May not require the enrollee to explain why the enrollee fears
14 that disclosure may lead to harassment or abuse or may undermine
15 the enrollee's ability to access health care.

16 (c) Shall ensure that the confidential communications request re-
17 mains in effect until the enrollee revokes the request in writing or
18 submits a new confidential communications request.

19 (d) Shall ensure that the confidential communications request is
20 acted upon and implemented by the carrier or third party administra-
21 tor not later than seven days after receipt of a request by electronic
22 means or 30 days after receipt of a request in hard copy.

23 (e) May not require an enrollee to waive any right to limit disclo-
24 sure under this section as a condition of eligibility for or coverage
25 under a health benefit plan.

26 (f) Must be easy to understand and to complete.

27 (4) A provider may make an arrangement with an enrollee for the
28 enrollee to pay to the provider any cost sharing required under the
29 health benefit plan and shall communicate the arrangement to the
30 carrier or third party administrator.

31 (5) The Department of Consumer and Business Services shall work
32 with stakeholders to develop and make available to the public a
33 standardized form that an enrollee may submit to a carrier or third
34 party administrator to make a confidential communications request.
35 The department shall encourage health care providers to clearly dis-
36 play the form and make it available to patients. At a minimum, the
37 form must:

1 “(a) Inform an enrollee about the enrollee’s right to have personal
2 health information sent to the enrollee and not disclosed to the
3 policyholder or certificate holder; or

4 “(b) Allow an enrollee to indicate whether communications con-
5 taining personal health information should be withheld by the carrier
6 or third party administrator or should be redirected to a specified mail
7 or electronic mail address or specified telephone number;

8 “(c) Allow an enrollee to designate a mail or electronic mail address
9 or telephone number for the carrier or third party administrator to
10 contact the enrollee if additional information or clarification is nec-
11 essary to process the confidential communications request; and

12 “(d) Include a disclaimer that it may take up to 30 days from the
13 date of receipt for a carrier or third party administrator to process the
14 form.

15 “(6) The department shall work with carriers, third party adminis-
16 trators and other stakeholders to develop effective systems to protect
17 the confidentiality of personal health information and to ensure that
18 carriers and third party administrators communicate directly with an
19 enrollee regarding health care services sought or received by the
20 enrollee.

21 “(7) The department shall interpret this section in a manner that
22 is consistent with federal law.

23 “SECTION 3. (1) No later than February 1, 2017, the Department of
24 Consumer and Business Services shall report, in the manner pre-
25 scribed by ORS 192.245, on:

26 “(a) The effectiveness of the process described in section 2 of this
27 2015 Act in allowing health insurance enrollees to redirect insurance
28 communications containing personal health information, the extent
29 to which enrollees are using the process and whether the process is
30 working properly; and

31 “(b) The education and outreach activities conducted by carriers or
32 third party administrators to inform Oregonians about their right to
33 have personal health information redirected.

34 “(2) The department shall require carriers or third party adminis-

HB 2758

40

1 trators to report data necessary for the department to produce the
2 report described in subsection (1) of this section.”.

41 **SECTION 4.** ORS 743.801 is amended to read:

42 743.801. As used in this section and ORS 743.803, 743.804, 743.806, 743.807, 743.808, 743.811,
43 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854,
44 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913,
45 743.917 and 743.918 and section 2 of this 2015 Act:

[3d]

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

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

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

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

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

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

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

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

16 (4) "Grievance" means:

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

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

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

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

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

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

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

30 (5) "Health benefit plan" has the meaning given that term in ORS 743.730.

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

36 (7) "Insurer" includes a health care service contractor as defined in ORS 750.005.

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

39 (9) "Managed health insurance" means any health benefit plan that:

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

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

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

8 (11)(a) "Preferred provider organization insurance" means any health benefit plan that:

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

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

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

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

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

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

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

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

30 743.801. As used in this section and ORS 743.065, 743.803, 743.804, 743.806, 743.807, 743.808,
 31 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839,
 32 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912,
 33 743.913, 743.917 and 743.918 **and section 2 of this 2015 Act:**

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

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

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

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

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

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

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

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

4 (4) "Grievance" means:

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

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

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

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

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

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

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

18 (5) "Health benefit plan" has the meaning given that term in ORS 743.730.

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

24 (7) "Insurer" includes a health care service contractor as defined in ORS 750.005.

25 (8) "Internal appeal" means a review by an insurer of an adverse benefit determination made
26 by the insurer.

27 (9) "Managed health insurance" means any health benefit plan that:

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

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

34 (10) "Medical services contract" means a contract between an insurer and an independent
35 practice association, between an insurer and a provider, between an independent practice associ-
36 ation and a provider or organization of providers, between medical or mental health clinics, and
37 between a medical or mental health clinic and a provider to provide medical or mental health ser-
38 vices. "Medical services contract" does not include a contract of employment or a contract creating
39 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other
40 similar professional organizations permitted by statute.

41 (11)(a) "Preferred provider organization insurance" means any health benefit plan that:

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

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

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

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

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

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

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

16 **SECTION 6.** ORS 743.804 is amended to read:

17 743.804. All insurers offering a health benefit plan in this state shall:

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

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

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

23 (B) To be treated with respect and with recognition of the enrollee's dignity and need for pri-
 24 vacy.

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

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

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

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

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

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

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

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

40 (d) A summary of the insurer's policies on prescription drugs, including:

41 (A) Cost-sharing differentials;

42 (B) Restrictions on coverage;

43 (C) Prescription drug formularies;

44 (D) Procedures by which a provider with prescribing authority may prescribe drugs not included
 45 on the formulary;

- 1 (E) Procedures for the coverage of prescription drugs not included on the formulary; and
- 2 (F) A summary of the criteria for determining whether a drug is experimental or investigational.
- 3 (e) A list of network providers and how the enrollee can obtain current information about the
- 4 availability of providers and how to access and schedule services with providers, including clinic
- 5 and hospital networks.
- 6 (f) Notice of the enrollee's right to select a primary care provider and specialty care providers.
- 7 (g) How to obtain referrals for specialty care in accordance with ORS 743.856.
- 8 (h) Restrictions on services obtained outside of the insurer's network or service area.
- 9 (i) The availability of continuity of care as required by ORS 743.854.
- 10 (j) Procedures for accessing after-hours care and emergency services as required by ORS
- 11 743A.012.

- 12 (k) Cost-sharing requirements and other charges to enrollees.
- 13 (L) Procedures, if any, for changing providers.
- 14 (m) Procedures, if any, by which enrollees may participate in the development of the insurer's
- 15 corporate policies.

- 16 (n) A summary of how the insurer makes decisions regarding coverage and payment for treat-
- 17 ment or services, including a general description of any prior authorization and utilization control
- 18 requirements that affect coverage or payment.

- 19 (o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other provid-
- 20 ers.

- 21 (p) A summary of the insurer's procedures for protecting the confidentiality of medical records
- 22 and other enrollee information ~~and the requirements of and the procedure adopted under sec-~~
- 23 ~~tion 2 of this 2015 Act including, but not limited to, an enrollee's right to make a confidential~~
- 24 ~~communications request and the requirement that an insurer send communications regard-~~
- 25 ~~ing sensitive services only to the enrollee who sought or received the services.~~

25a "and the requirement under section 2 of this 2015 Act that a carrier or third
 25b party administrator send communications containing personal health infor-
 25c mation only to the enrollee who is the subject of the personal health infor-
 25d mation".

- 26 (q) An explanation of assistance provided to non-English-speaking enrollees.
- 27 (r) Notice of the information available from the department that is filed by insurers as required
- 28 under ORS 743.807, 743.814 and 743.817.

29 (2) Establish procedures for making coverage determinations and resolving grievances that pro-
 30 vide for all of the following:

- 31 (a) Timely notice of adverse benefit determinations in a form and manner approved by the de-
- 32 partment or prescribed by the department by rule.
- 33 (b) A method for recording all grievances, including the nature of the grievance and significant
- 34 action taken.
- 35 (c) Written decisions meeting criteria established by the Director of the Department of Con-
- 36 sumer and Business Services by rule.
- 37 (d) An expedited response to a request for an internal appeal that accommodates the clinical
- 38 urgency of the situation.

39 (e) At least one but not more than two levels of internal appeal for group health benefit plans
 40 and one level of internal appeal for individual health benefit plans. If an insurer provides:

- 41 (A) Two levels of internal appeal, a person who was involved in the consideration of the initial
- 42 denial or the first level of internal appeal may not be involved in the second level of internal appeal;
- 43 and

HB 2758

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

[8a]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44 (8) Provide an annual summary to the department of the insurer's aggregate data regarding
 45 grievances, internal appeals and requests for external review in a format prescribed by the depart-

1 ment to ensure consistent reporting on the number, nature and disposition of grievances, internal
2 appeals and requests for external review.

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

4 **SECTION 7.** ORS 746.607 is amended to read:

5 **746.607. Except as provided in section 2 of this 2015 Act,** a health insurer:

6 (1) May use or disclose personal information of an individual in a manner that is consistent with
7 an authorization provided by the individual or a personal representative of the individual.

8 (2) May use or disclose protected health information of an individual without obtaining an au-
9 thorization from the individual or a personal representative of the individual:

10 (a) For its own treatment, payment or health care operations; or

11 (b) As otherwise permitted or required by state or federal law or by order of the court.

12 (3) May disclose, subject to any requirements established by rule under ORS 746.608 and con-
13 sistent with federal law, protected health information of an individual without obtaining an author-
14 ization from the individual or a personal representative of the individual:

15 (a) To another covered entity for health care operations activities of the entity that receives the
16 information if:

17 (A) Each entity has or had a relationship with the individual who is the subject of the protected
18 health information; and

19 (B) The protected health information pertains to the relationship and the disclosure is for the
20 purpose of:

21 (i) Health care operations listed in ORS 746.600 (13)(a) or (b); or

22 (ii) Health care fraud and abuse detection or compliance;

23 (b) To another covered entity or any other health care provider for treatment activities of a
24 health care provider; or

25 (c) To another covered entity or any other health care provider for the payment activities of the
26 entity that receives the information.

27 (4) May use or disclose personal financial information of an individual:

28 (a) To perform a business, professional or insurance function, subject to any requirements es-
29 tablished by rule under ORS 746.608 for an authorization by an individual or a personal represen-
30 tative of an individual; or

31 (b) Without obtaining an authorization by the individual or the personal representative of the
32 individual as otherwise permitted or required by state or federal law or by order of the court.

33 (5) May charge a reasonable, cost-based fee, provided that the fee includes only the cost of:

34 (a) Copying personal information requested by an individual or a personal representative of the
35 individual, including the cost of supplies for and labor of copying;

36 (b) Postage, when an individual or a personal representative of the individual has requested that
37 copies of personal information or an explanation or summary of protected health information be
38 mailed; or

39 (c) Preparing an explanation or summary of personal information if requested by an individual
40 or a personal representative of the individual.

41 (6) Shall provide adequate notice of the uses and disclosures of personal information that may
42 be made by the health insurer and of the individual's rights and the health insurer's legal duties
43 with respect to personal information.

44 (7) Shall permit an individual or a personal representative of an individual to request:

45 (a) Access to inspect or obtain a copy of the individual's personal financial information or pro-

1 tected health information that is maintained in a designated record set about the individual; or

2 (b) That the health insurer correct, amend or delete personal information.

3 **SECTION 8.** ORS 750.055, as amended by section 5, chapter 25, Oregon Laws 2014, and section
4 80, chapter 45, Oregon Laws 2014, is amended to read:

5 750.055. (1) The following provisions of the Insurance Code apply to health care service con-
6 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

7 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,
8 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,
9 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,
10 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

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

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

15 (d) ORS chapter 734.

16 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to
17 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,
18 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550 to
19 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to
20 743.839, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864,
21 743.894, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036,
22 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082,
23 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144,
24 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188,
25 743A.190, 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, [and] section 2,
26 chapter 25, Oregon Laws 2014, and section 2 of this 2015 Act.

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

28 (g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
29 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

34 (i) ORS 735.600 to 735.650.

35 (j) ORS 743.680 to 743.689.

36 (k) ORS 744.700 to 744.740.

37 (L) ORS 743.730 to 743.773.

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

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

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

45 (4) The Director of the Department of Consumer and Business Services may, after notice and

1 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
 2 and 750.045 that are deemed necessary for the proper administration of these provisions.

3 **SECTION 9.** ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section
 4 6, chapter 25, Oregon Laws 2014, and section 81, chapter 45, Oregon Laws 2014, is amended to read:

5 750.055. (1) The following provisions of the Insurance Code apply to health care service con-
 6 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

7 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,
 8 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,
 9 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,
 10 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

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

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

15 (d) ORS chapter 734.

16 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to
 17 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,
 18 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550, 743.552,
 19 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to 743.839,
 20 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894,
 21 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048,
 22 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084,
 23 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148,
 24 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190,
 25 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, [and] section 2, chapter 25,
 26 Oregon Laws 2014, and section 2 of this 2015 Act.

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

28 (g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
 29 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

34 (i) ORS 743.680 to 743.689.

35 (j) ORS 744.700 to 744.740.

36 (k) ORS 743.730 to 743.773.

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

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

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

44 (4) The Director of the Department of Consumer and Business Services may, after notice and
 45 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025

1 and 750.045 that are deemed necessary for the proper administration of these provisions.

2 **SECTION 10.** ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section
 3 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, and section 82, chapter
 4 45, Oregon Laws 2014, is amended to read:

5 750.055. (1) The following provisions of the Insurance Code apply to health care service con-
 6 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

7 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,
 8 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,
 9 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,
 10 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

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

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

15 (d) ORS chapter 734.

16 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to
 17 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,
 18 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550, 743.552,
 19 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to 743.839,
 20 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894,
 21 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048,
 22 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084,
 23 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148,
 24 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190,
 25 743A.192 and 743A.250 and section 2, chapter 25, Oregon Laws 2014, and **section 2 of this 2015**
 26 **Act.**

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

28 (g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
 29 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

34 (i) ORS 743.680 to 743.689.

35 (j) ORS 744.700 to 744.740.

36 (k) ORS 743.730 to 743.773.

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

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

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

44 (4) The Director of the Department of Consumer and Business Services may, after notice and
 45 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025

1 and 750.045 that are deemed necessary for the proper administration of these provisions.

2 **SECTION 11.** ORS 750.333, as amended by section 8, chapter 25, Oregon Laws 2014, is amended
3 to read:

4 750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a mul-
5 tiple employer welfare arrangement:

6 (a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
7 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
8 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 to 731.992 and 743.061.

9 (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.

10 (c) ORS chapter 734.

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

12 (e) ORS 743.028, 743.053, 743.499, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560,
13 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.766 to 743.773), 743.801,
14 743.804, 743.807, 743.808, 743.814 to 743.839, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858,
15 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.912, 743.917, 743A.012, 743A.020, 743A.034,
16 743A.052, 743A.064, 743A.065, 743A.080, 743A.082, 743A.100, 743A.104, 743A.110, 743A.144, 743A.150,
17 743A.170, 743A.175, 743A.184, 743A.192 and 743A.250 and section 2, chapter 25, Oregon Laws 2014,
18 and section 2 of this 2015 Act.

19 (f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048,
20 743A.058, 743A.066, 743A.068, 743A.070, 743A.084, 743A.088, 743A.090, 743A.105, 743A.140, 743A.141,
21 743A.148, 743A.168, 743A.180, 743A.185, 743A.188 and 743A.190. Multiple employer welfare arrange-
22 ments to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this para-
23 graph only as provided in ORS 743.730 to 743.773.

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

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

27 (i) ORS 731.592 and 731.594.

28 (j) ORS 731.870.

29 (2) For the purposes of this section:

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

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

33 (c) Contributions shall be considered premiums.

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

36 **SECTION 12.** The Department of Consumer and Business Services shall work with
37 stakeholders and consumer groups to develop the standardized form described in section 2
38 of this 2015 Act and shall make the form available to the public not later than 90 days after
39 the effective date of this 2015 Act.

39a **SECTION 13.** Section 2 of this 2015 Act applies to health benefit
39b plans issued or renewed on or after January 1, 2016.

39c **SECTION 14.** This 2015 Act being necessary for the immediate
39d preservation of the public peace, health and safety, an emergency is
39e declared to exist, and this 2015 Act takes effect on its passage.”