

Senate Bill 1568

Sponsored by Senator WINTERS, Representative KENNEMER, Senators SHIELDS, BATES; Senators FERRIOLI, KNOPP, KRUSE, Representatives FAGAN, HOYLE, LIVELY, OLSON (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 discrimination based on age, expected length of life, present or predicted disability, degree of medical dependency or quality of life in determination of medical services covered by state medical assistance program, in coverage under medical retainer practice and in issuance of health benefit plans. Applies to medical retainer practices and health benefit plans in force on January 2, 2017.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to discrimination; creating new provisions; amending ORS 414.065, 414.690, 735.500, 743.535,
3 743B.003, 743B.005, 743B.011, 743B.012, 743B.013, 743B.104, 743B.105, 743B.125 and 743B.126; and
4 declaring an emergency.

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

6 **SECTION 1.** ORS 414.065 is amended to read:

7 414.065. (1)(a) With respect to health care and services to be provided in medical assistance
8 during any period, the Oregon Health Authority shall determine, subject to such revisions as it may
9 make from time to time and subject to legislative funding and paragraph (b) of this subsection:

10 (A) The types and extent of health care and services to be provided to each eligible group of
11 recipients of medical assistance.

12 (B) Standards, including outcome and quality measures, to be observed in the provision of health
13 care and services.

14 (C) The number of days of health care and services toward the cost of which medical assistance
15 funds will be expended in the care of any person.

16 (D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing
17 health services to an applicant or recipient.

18 (E) Reasonable fees for professional medical and dental services which may be based on usual
19 and customary fees in the locality for similar services.

20 (F) The amount and application of any copayment or other similar cost-sharing payment that the
21 authority may require a recipient to pay toward the cost of health care or services.

22 (b) The authority shall adopt rules establishing timelines for payment of health services under
23 paragraph (a) of this subsection.

24 (2) The types and extent of health care and services and the amounts to be paid in meeting the
25 costs thereof, as determined and fixed by the authority and within the limits of funds available
26 therefor, shall be the total available for medical assistance and payments for such medical assistance
27 shall be the total amounts from medical assistance funds available to providers of health care and
28 services in meeting the costs thereof.

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 (3) Except for payments under a cost-sharing plan, payments made by the authority for medical
 2 assistance shall constitute payment in full for all health care and services for which such payments
 3 of medical assistance were made.

4 (4) Notwithstanding subsections (1) and (2) of this section, the Department of Human Services
 5 shall be responsible for determining the payment for Medicaid-funded long term care services and
 6 for contracting with the providers of long term care services.

7 (5) In determining a global budget for a coordinated care organization:

8 (a) The allocation of the payment, the risk and any cost savings shall be determined by the
 9 governing body of the organization;

10 (b) The authority shall consider the community health assessment conducted by the organization
 11 and reviewed annually, and the organization's health care costs; and

12 (c) The authority shall take into account the organization's provision of innovative, nontradi-
 13 tional health services.

14 (6) Under the supervision of the Governor, the authority may work with the Centers for Medi-
 15 care and Medicaid Services to develop, in addition to global budgets, payment streams:

16 (a) To support improved delivery of health care to recipients of medical assistance; and

17 (b) That are funded by coordinated care organizations, counties or other entities other than the
 18 state whose contributions qualify for federal matching funds under Title XIX or XXI of the Social
 19 Security Act.

20 **(7) In determining the types and extent of health care and services to be provided to each**
 21 **eligible group of recipients of medical assistance, the authority:**

22 **(a) Shall take into account the health care needs of diverse segments of Oregon's popu-**
 23 **lation; and**

24 **(b) Shall ensure that the services are not denied to an individual on the basis of the**
 25 **individual's age, expected length of life, present or predicted disability, degree of medical**
 26 **dependency or quality of life.**

27 **SECTION 2.** ORS 414.690 is amended to read:

28 414.690. (1) The Health Evidence Review Commission shall regularly solicit testimony and in-
 29 formation from stakeholders representing consumers, advocates, providers, carriers and employers
 30 in conducting the work of the commission.

31 (2) The commission shall actively solicit public involvement through a public meeting process
 32 to guide health resource allocation decisions.

33 (3)(a) The commission shall develop and maintain a list of health services ranked by priority,
 34 from the most important to the least important, representing the comparative benefits of each ser-
 35 vice to the population to be served.

36 **(b) In determining the ranking of services on the list and in the development and imple-**
 37 **mentation of guidelines associated with the list, the commission:**

38 **(A) Shall take into account the health care needs of diverse segments of Oregon's popu-**
 39 **lation; and**

40 **(B) Shall ensure that services are not denied to an individual on the basis of the**
 41 **individual's age, expected length of life, present or predicted disability, degree of medical**
 42 **dependency or quality of life.**

43 (c) The list must be submitted by the commission pursuant to subsection (5) of this section and
 44 is not subject to alteration by any other state agency.

45 (4) In order to encourage effective and efficient medical evaluation and treatment, the commis-

1 sion:

2 (a) May include clinical practice guidelines in its prioritized list of services. The commission
3 shall actively solicit testimony and information from the medical community and the public to build
4 a consensus on clinical practice guidelines developed by the commission.

5 (b) May include statements of intent in its prioritized list of services. Statements of intent should
6 give direction on coverage decisions where medical codes and clinical practice guidelines cannot
7 convey the intent of the commission.

8 (c) Shall consider both the clinical effectiveness and cost-effectiveness of health services, in-
9 cluding drug therapies, in determining their relative importance using peer-reviewed medical litera-
10 ture as defined in ORS 743A.060.

11 (5) The commission shall report the prioritized list of services to the Oregon Health Authority
12 for budget determinations by July 1 of each even-numbered year.

13 (6) The commission shall make its report during each regular session of the Legislative Assem-
14 bly and shall submit a copy of its report to the Governor, the Speaker of the House of Represen-
15 tatives and the President of the Senate.

16 (7) The commission may alter the list during the interim only as follows:

17 (a) To make technical changes to correct errors and omissions;

18 (b) To accommodate changes due to advancements in medical technology or new data regarding
19 health outcomes;

20 (c) To accommodate changes to clinical practice guidelines; and

21 (d) To add statements of intent that clarify the prioritized list.

22 (8) If a service is deleted or added during an interim and no new funding is required, the com-
23 mission shall report to the Speaker of the House of Representatives and the President of the Senate.
24 However, if a service to be added requires increased funding to avoid discontinuing another service,
25 the commission shall report to the Emergency Board to request the funding.

26 (9) The prioritized list of services remains in effect for a two-year period beginning no earlier
27 than October 1 of each odd-numbered year.

28 **SECTION 3.** ORS 735.500 is amended to read:

29 735.500. (1) As used in this section and ORS 735.510:

30 (a) "Control" means the possession, directly or indirectly, of the power to direct or cause the
31 direction of the management and policies of a person, whether through the ownership of voting
32 stock, by contract or otherwise. A person who is the owner of 10 percent or more ownership interest
33 in a retainer medical practice or applicant for a certificate to operate a retainer medical practice
34 is presumed to have control.

35 (b) "Primary care" means outpatient, nonspecialty medical services or the coordination of health
36 care for the purpose of:

37 (A) Promoting or maintaining mental and physical health and wellness; and

38 (B) Diagnosis, treatment or management of acute or chronic conditions caused by disease, injury
39 or illness.

40 (c) "Provider" means a health care professional licensed or certified under ORS chapter 677, 678,
41 684 or 685 who provides primary care in the ordinary course of business or practice of a profession.

42 (d) "Retainer medical agreement" means a written agreement between a retainer medical prac-
43 tice and a patient or a legal representative or guardian of a patient specifying a defined and pre-
44 determined set of primary care services to be provided in consideration for a retainer medical fee.

45 (e) "Retainer medical fee" means any fee paid to a retainer medical practice pursuant to a

1 medical retainer agreement.

2 (f) "Retainer medical practice" means a provider, a group of providers or a person that employs
3 or contracts with a provider or a group of providers to provide services under the terms of a
4 retainer medical agreement.

5 (2) A retainer medical practice must be certified by the Department of Consumer and Business
6 Services. To qualify to become a certified retainer medical practice or to renew a certificate, the
7 practice:

8 (a) May not have or have ever had a certificate of authority to transact insurance in this state.

9 (b) May not be or have ever been licensed, certified or otherwise authorized in this state or any
10 other state to act as an insurer, managed care organization, health care service contractor or sim-
11 ilar entity.

12 (c) May not be controlled by an entity described in paragraph (a) or (b) of this subsection.

13 (3) A certified retainer medical practice:

14 (a) Must provide only primary care and must limit the scope of services provided or the number
15 of patients served to an amount that is within the capacity of the practice to provide in a timely
16 manner;

17 (b) May not bill an insurer, a self-insured plan or the state medical assistance program for a
18 service provided by the practice to a patient pursuant to a retainer medical agreement;

19 (c) Must be financially responsible and have the necessary business experience or expertise to
20 operate the practice;

21 (d) Must give the written disclosures described in subsection (4) of this section;

22 (e) May not use or disseminate misleading, deceptive or false statements in marketing, adver-
23 tising, promotional, sales or informational materials regarding the practice or in communications
24 with patients or prospective patients;

25 (f) May not engage in dishonest, fraudulent or illegal conduct in any business or profession; and

26 (g) May not discriminate based on race, religion, gender, sexual identity, sexual preference,
27 [or] health status, **age, expected length of life, present or predicted disability, degree of med-**
28 **ical dependency or quality of life.**

29 (4) A certified retainer medical practice must make the following written information available
30 to prospective patients by prominently disclosing, in the manner prescribed by the department by
31 rule, in marketing materials and retainer medical agreements:

32 (a) That the practice is not insurance;

33 (b) That the practice provides only the limited scope of primary care services specified in the
34 retainer medical agreement;

35 (c) That a patient must pay for all services not specified in the retainer medical agreement; and

36 (d) Any other disclosures required by the department by rule.

37 (5) The department may by written order deny, suspend or revoke a retainer medical practice
38 certificate or may refuse to renew a retainer medical practice certificate if the department finds
39 that:

40 (a) The retainer medical practice does not meet the criteria in subsections (2) to (4) of this
41 section;

42 (b) The retainer medical practice has provided false, misleading, incomplete or inaccurate in-
43 formation in the application for a certificate or renewal of a certificate;

44 (c) The retainer medical practice provides medical services through a provider whose license to
45 provide the medical services offered on behalf of the retainer medical practice is revoked;

1 (d) The authority of the retainer medical practice to operate a retainer medical practice or
2 similar practice in another jurisdiction is denied, suspended, revoked or not renewed;

3 (e) The retainer medical practice, a person who has control over the retainer medical practice
4 or a health care provider providing services on behalf of the retainer medical practice is charged
5 with a felony or misdemeanor involving dishonesty; or

6 (f) The retainer medical practice fails to comply with subsection (7) of this section.

7 (6) With respect to a certified retainer medical practice or a retainer medical practice operating
8 without a certificate, the department is authorized to:

9 (a) Investigate;

10 (b) Subpoena documents and records related to the business of the practice; and

11 (c) Take any actions authorized by the Insurance Code that are necessary to administer and
12 enforce this section.

13 (7) A retainer medical practice subject to an investigation under subsection (5) of this section
14 must:

15 (a) Within five business days, respond to inquiries in the form and manner specified by the de-
16 partment; and

17 (b) Reimburse the expenses incurred by the department in conducting the investigation.

18 (8) A retainer medical practice may contest any order made under subsection (5) of this section
19 in accordance with ORS chapter 183.

20 (9) A certificate issued under subsection (2) of this section is effective for one year or for a
21 longer period as prescribed by the department by rule.

22 (10) The department may adopt rules necessary or appropriate to implement the provisions of
23 this section.

24 **SECTION 4.** ORS 743.535 is amended to read:

25 743.535. (1) As used in this section, "guaranteed association" means an association that:

26 (a) The Director of the Department of Consumer and Business Services has determined under
27 ORS 743.524 meets the requirements described in ORS 731.098 (2); and

28 (b) Is a statewide nonprofit organization representing the interests of individuals licensed under
29 ORS chapter 696.

30 (2) A carrier may offer a health benefit plan to a guaranteed association if the plan provides
31 health benefits covering 500 or more members or dependents of members of the association.

32 (3) When a carrier offers coverage to a guaranteed association under subsection (2) of this sec-
33 tion, the carrier shall offer coverage to all members of the association and all dependents of the
34 members of the association without regard to the actual or expected health status, **age, expected**
35 **length of life, present or predicted disability, degree of medical dependency or quality of life**
36 of any member or any dependent of a member of the association.

37 (4) A carrier offering a health benefit plan under subsection (2) of this section shall establish
38 premium rates as follows:

39 (a) For the initial 12-month period of coverage, the carrier shall submit to the director a certi-
40 fied statement that the premium rates charged to the guaranteed association are actuarially sound.
41 The statement must be signed by an actuary certifying the accuracy of the rating methodology as
42 established by the American Academy of Actuaries.

43 (b) For any subsequent 12-month period of coverage, according to a rating methodology as es-
44 tablished by the American Academy of Actuaries.

45 (5) A member of a guaranteed association may apply for coverage offered by a carrier under

1 subsection (2) of this section only:

2 (a) If the member has been an active member of the association for no less than 30 days;

3 (b) During an annual open enrollment period offered by the association; and

4 (c) After meeting any additional eligibility requirements agreed upon by the association and the
5 carrier.

6 (6) Notwithstanding subsection (5) of this section, if a member or a dependent of a member of
7 a guaranteed association terminates coverage under the health benefit plan, the member or de-
8 pendent shall be excluded from coverage for 12 months from the date of termination of coverage.
9 The member may enroll for coverage of the member or the dependent during an annual open en-
10 rollment period following the expiration of the exclusion period.

11 **SECTION 5.** ORS 743B.003 is amended to read:

12 743B.003. The purposes of ORS 743.004, 743.022, 743.535, 743B.003 to 743B.127 and 743B.800 are:

13 (1) To promote the availability of health insurance coverage to groups regardless of their
14 enrollees' [*health status or*] claims experience, **health status, age, expected length of life, present**
15 **or predicted disability, degree of medical dependency or quality of life;**

16 (2) To prevent abusive rating practices;

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

19 (4) To prohibit the use of preexisting condition exclusions except in individual grandfathered
20 health plans;

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

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

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

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

30 **SECTION 6.** ORS 743B.005 is amended to read:

31 743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and
32 743B.128:

33 (1) "Actuarial certification" means a written statement by a member of the American Academy
34 of Actuaries or other individual acceptable to the Director of the Department of Consumer and
35 Business Services that a carrier is in compliance with the provisions of ORS 743B.012 based upon
36 the person's examination, including a review of the appropriate records and of the actuarial as-
37 sumptions and methods used by the carrier in establishing premium rates for small employer health
38 benefit plans.

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

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

45 (a) That is applied uniformly and without regard to any health status related factors to an

- 1 enrollee or late enrollee;
- 2 (b) That must expire before any coverage becomes effective under the plan for the enrollee or
3 late enrollee;
- 4 (c) During which no premium shall be charged to the enrollee or late enrollee; and
- 5 (d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs
6 concurrently with any eligibility waiting period under the plan.
- 7 (4) "Bona fide association" means an association that:
- 8 (a) Has been in active existence for at least five years;
- 9 (b) Has been formed and maintained in good faith for purposes other than obtaining insurance;
- 10 (c) Does not condition membership in the association on any factor relating to the health
11 status, **age, expected length of life, present or predicted disability, degree of medical depend-**
12 **ency or quality of life** of an individual or the individual's dependent or employee;
- 13 (d) Makes health insurance coverage that is offered through the association available to all
14 members of the association regardless of the health status, **age, expected length of life, present**
15 **or predicted disability, degree of medical dependency or quality of life** of the member or indi-
16 viduals who are eligible for coverage through the member;
- 17 (e) Does not make health insurance coverage that is offered through the association available
18 other than in connection with a member of the association;
- 19 (f) Has a constitution and bylaws; and
- 20 (g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.
- 21 (5) "Carrier" means any person who provides health benefit plans in this state, including:
- 22 (a) A licensed insurance company;
- 23 (b) A health care service contractor;
- 24 (c) A health maintenance organization;
- 25 (d) An association or group of employers that provides benefits by means of a multiple employer
26 welfare arrangement and that:
- 27 (A) Is subject to ORS 750.301 to 750.341; or
- 28 (B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by
29 ORS 743B.010 to 743B.013; or
- 30 (e) Any other person or corporation responsible for the payment of benefits or provision of ser-
31 vices.
- 32 (6) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms
33 of the health benefit plan covering the employee.
- 34 (7) "Eligible employee" means an employee who is eligible for coverage under a group health
35 benefit plan.
- 36 (8) "Employee" means any individual employed by an employer.
- 37 (9) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible
38 for a group or individual health benefit plan who has enrolled for coverage under the terms of the
39 plan.
- 40 (10) "Exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031,
41 18032, 18033 and 18041.
- 42 (11) "Exclusion period" means a period during which specified treatments or services are ex-
43 cluded from coverage.
- 44 (12) "Financial impairment" means that a carrier is not insolvent and is:
- 45 (a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

- 1 (b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.
- 2 (13)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the
- 3 corresponding highest premium to be charged by a carrier in a geographic area established by the
- 4 director for the carrier's:
- 5 (A) Group health benefit plans offered to small employers; or
- 6 (B) Individual health benefit plans.
- 7 (b) "Geographic average rate" does not include premium differences that are due to differences
- 8 in benefit design, age, tobacco use or family composition.
- 9 (14) "Grandfathered health plan" has the meaning prescribed by the United States Secretaries
- 10 of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).
- 11 (15) "Group eligibility waiting period" means, with respect to a group health benefit plan, the
- 12 period of employment or membership with the group that a prospective enrollee must complete be-
- 13 fore plan coverage begins.
- 14 (16)(a) "Health benefit plan" means any:
- 15 (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;
- 16 (B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or
- 17 (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-
- 18 ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the
- 19 extent that the plan is subject to state regulation.
- 20 (b) "Health benefit plan" does not include:
- 21 (A) Coverage for accident only, specific disease or condition only, credit or disability income;
- 22 (B) Coverage of Medicare services pursuant to contracts with the federal government;
- 23 (C) Medicare supplement insurance policies;
- 24 (D) Coverage of TRICARE services pursuant to contracts with the federal government;
- 25 (E) Benefits delivered through a flexible spending arrangement established pursuant to section
- 26 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition
- 27 to a group health benefit plan;
- 28 (F) Separately offered long term care insurance, including, but not limited to, coverage of nurs-
- 29 ing home care, home health care and community-based care;
- 30 (G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity in-
- 31 surance;
- 32 (H) Short term health insurance policies that are in effect for periods of 12 months or less, in-
- 33 cluding the term of a renewal of the policy;
- 34 (I) Dental only coverage;
- 35 (J) Vision only coverage;
- 36 (K) Stop-loss coverage that meets the requirements of ORS 742.065;
- 37 (L) Coverage issued as a supplement to liability insurance;
- 38 (M) Insurance arising out of a workers' compensation or similar law;
- 39 (N) Automobile medical payment insurance or insurance under which benefits are payable with
- 40 or without regard to fault and that is statutorily required to be contained in any liability insurance
- 41 policy or equivalent self-insurance; or
- 42 (O) Any employee welfare benefit plan that is exempt from state regulation because of the fed-
- 43 eral Employee Retirement Income Security Act of 1974, as amended.
- 44 (c) For purposes of this subsection, renewal of a short term health insurance policy includes the
- 45 issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days

1 after the expiration of a policy previously issued by the insurer to the policyholder.

2 (17) "Individual health benefit plan" means a health benefit plan:

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

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

6 (18) "Initial enrollment period" means a period of at least 30 days following commencement of
7 the first eligibility period for an individual.

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

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

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

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

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

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

23 (20) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement
24 as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended,
25 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

26 (21) "Preexisting condition exclusion" means:

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

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

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

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

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

44 (25) "Small employer" has the meaning given that term in 42 U.S.C. 18024 unless otherwise
45 prescribed by the department by rule in accordance with guidance issued by the United States De-

1 partment of Health and Human Services, the United States Department of Labor or the United
2 States Department of the Treasury.

3 **SECTION 7.** ORS 743B.011 is amended to read:

4 743B.011. (1) Every health benefit plan shall be subject to the provisions of ORS 743B.010 to
5 743B.013, if the plan provides health benefits covering one or more employees of a small employer
6 and if any one of the following conditions is met:

7 (a) Any portion of the premium or benefits is paid by a small employer or any employee is re-
8 imursed, whether through wage adjustments or otherwise, by a small employer for any portion of
9 the health benefit plan premium; or

10 (b) The health benefit plan is treated by the employer or any of the employees as part of a plan
11 or program for the purposes of section 106, section 125 or section 162 of the Internal Revenue Code
12 of 1986, as amended.

13 (2) Except as otherwise provided by ORS 743B.010 to 743B.013 or other law, no health benefit
14 plan offered to a small employer shall:

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

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

19 (3)(a) A carrier may provide different health benefit plans to different categories of employees
20 of a small employer when the employer has chosen to establish different categories of employees in
21 a manner that does not relate to the actual or expected health status, **age, expected length of life,**
22 **present or predicted disability, degree of medical dependency or quality of life** of such em-
23 ployees or their dependents. The categories must be based on bona fide employment-based classi-
24 fications that are consistent with the employer's usual business practice.

25 (b) Except as provided in ORS 743B.012 (7), a carrier that offers coverage to a small employer
26 shall offer coverage to all eligible employees of the small employer.

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

29 (4) An insurer may not deny, delay or terminate participation of an individual in a group health
30 benefit plan or exclude coverage otherwise provided to an individual under a group health benefit
31 plan based on a preexisting condition of the individual.

32 **SECTION 8.** ORS 743B.012 is amended to read:

33 743B.012. (1) As a condition of transacting business in the small employer health insurance
34 market in this state, a carrier shall offer small employers all of the carrier's health benefit plans,
35 approved by the Department of Consumer and Business Services for use in the small employer
36 market, for which the small employer is eligible.

37 (2) A carrier shall issue to a small employer any health benefit plan that is offered by the car-
38 rier if the small employer applies for the plan and agrees to make the required premium payments
39 and to satisfy the other provisions of the health benefit plan.

40 (3) A multiple employer welfare arrangement, professional or trade association or other similar
41 arrangement established or maintained to provide benefits to a particular trade, business, profession
42 or industry or their subsidiaries may not issue coverage to a group or individual that is not in the
43 same trade, business, profession or industry as that covered by the arrangement. The arrangement
44 shall accept all groups and individuals in the same trade, business, profession or industry or their
45 subsidiaries that apply for coverage under the arrangement and that meet the requirements for

1 membership in the arrangement. For purposes of this subsection, the requirements for membership
2 in an arrangement may not include any requirements that relate to the actual or expected health
3 status, **age, expected length of life, present or predicted disability, degree of medical depend-**
4 **ency or quality of life** of the prospective enrollee.

5 (4) A carrier shall, pursuant to subsection (2) of this section, accept applications from and offer
6 coverage to a small employer group covered under an existing health benefit plan regardless of
7 whether a prospective enrollee is excluded from coverage under the existing plan because of late
8 enrollment. When a carrier accepts an application for a small employer group, the carrier may
9 continue to exclude the prospective enrollee excluded from coverage by the replaced plan until the
10 prospective enrollee would have become eligible for coverage under that replaced plan.

11 (5) A carrier is not required to accept applications from and offer coverage pursuant to sub-
12 section (2) of this section if the department finds that acceptance of an application or applications
13 would endanger the carrier's ability to fulfill its contractual obligations or result in financial
14 impairment of the carrier.

15 (6) A carrier shall actively market all health benefit plans that are offered by the carrier to
16 small employers in the geographical areas in which the carrier makes coverage available or provides
17 benefits.

18 (7)(a) Subsection (2) of this section does not require a carrier to offer coverage to or accept
19 applications from:

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

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

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

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

31 (8) For purposes of ORS 743B.010 to 743B.013, except as provided in this subsection, carriers
32 that are affiliated carriers or that are eligible to file a consolidated tax return pursuant to ORS
33 317.715 shall be treated as one carrier and any restrictions or limitations imposed by ORS 743B.010
34 to 743B.013 apply as if all health benefit plans delivered or issued for delivery to small employers
35 in this state by the affiliated carriers were issued by one carrier. However, any insurance company
36 or health maintenance organization that is an affiliate of a health care service contractor located
37 in this state, or any health maintenance organization located in this state that is an affiliate of an
38 insurance company or health care service contractor, may treat the health maintenance organization
39 as a separate carrier and each health maintenance organization that operates only one health
40 maintenance organization in a service area in this state may be considered a separate carrier.

41 (9) A carrier that elects to discontinue offering all of its health benefit plans to small employers
42 under ORS 743B.013 (3)(e) or elects to discontinue renewing all such plans is prohibited from offer-
43 ing health benefit plans to small employers in this state for a period of five years from one of the
44 following dates:

45 (a) The date of notice to the department pursuant to ORS 743B.013 (3)(e); or

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

4 **SECTION 9.** ORS 743B.013 is amended to read:

5 743B.013. (1) A health benefit plan issued to a small employer:

6 (a) Other than a grandfathered health plan, must cover essential health benefits consistent with
7 42 U.S.C. 300gg-11.

8 (b) May require an affiliation period that does not exceed two months for an enrollee or 90 days
9 for a late enrollee.

10 (c) May not apply a preexisting condition exclusion to any enrollee.

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

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

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

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

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

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

23 (e) The carrier discontinues both offering and renewing all of its small employer health benefit
24 plans in this state or in a specified service area within this state. In order to discontinue plans un-
25 der this paragraph, the carrier:

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

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

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

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

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

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

42 (C) Must offer in writing to each small employer covered by the plan, all other small employer
43 health benefit plans that the carrier offers to small employers in the specified service area. The
44 carrier shall issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013. The
45 carrier shall offer the plans at least 90 days prior to discontinuation.

1 (g) The carrier discontinues both offering and renewing a health benefit plan, other than a
2 grandfathered health plan, for all small employers in this state or in a specified service area within
3 this state, other than a plan discontinued under paragraph (f) of this subsection.

4 (h) The carrier discontinues both offering and renewing a grandfathered health plan for all small
5 employers in this state or in a specified service area within this state, other than a plan discontin-
6 ued under paragraph (f) of this subsection.

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

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

11 (B) Issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013.

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

13 (D) Act uniformly without regard to the claims experience of the affected policyholders or the
14 health status, **age, expected length of life, present or predicted disability, degree of medical**
15 **dependency or quality of life** of any current or prospective enrollee.

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

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

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

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

24 (L) In the case of a health benefit plan that is offered in the small employer market only to one
25 or more bona fide associations, the membership of an employer in the association ceases and the
26 termination of coverage is not related to the health status, **age, expected length of life, present**
27 **or predicted disability, degree of medical dependency or quality of life** of any enrollee.

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

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

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

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

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

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

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

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

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

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

45 (B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the

1 plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

45 (d) A carrier may not increase the rates of a health benefit plan issued to a small employer more

1 than once in a 12-month period. Annual rate increases shall be effective on the plan anniversary
2 date of the health benefit plan issued to a small employer. The percentage increase in the premium
3 rate charged to a small employer for a new rating period may not exceed the sum of the following:

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

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

7 (9) Premium rates for grandfathered health plans shall be subject to requirements prescribed by
8 the department by rule.

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

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

12 (b) The authority of the carrier to adjust rates and premiums, and the extent to which the car-
13 rier considers age, tobacco use, family composition and geographic factors in establishing and ad-
14 justing rates and premiums; and

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

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

22 (b) A carrier offering a small employer health benefit plan shall file with the department at least
23 once every 12 months an actuarial certification that the carrier is in compliance with ORS 743B.010
24 to 743B.013 and that the rating methods of the carrier are actuarially sound. Each certification shall
25 be in a uniform form and manner and shall contain such information as specified by the department.
26 A copy of each certification shall be retained by the carrier at its principal place of business. A
27 carrier is not required to file the actuarial certification under this paragraph if the department has
28 approved the carrier's rate filing within the preceding 12-month period.

29 (c) A carrier shall make the information and documentation described in paragraph (a) of this
30 subsection available to the department upon request. Except as provided in ORS 743.018 and except
31 in cases of violations of ORS 743B.010 to 743B.013, the information shall be considered proprietary
32 and trade secret information and shall not be subject to disclosure to persons outside the depart-
33 ment except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

34 (12) A carrier shall not provide any financial or other incentive to any insurance producer that
35 would encourage the insurance producer to sell health benefit plans of the carrier to small employer
36 groups based on a small employer group's anticipated claims experience.

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

39 (14) A carrier must include a provision that offers coverage to all eligible employees of a small
40 employer and to all dependents of the eligible employees to the extent the employer chooses to offer
41 coverage to dependents.

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

45 (16) A small employer health benefit plan may not impose annual or lifetime limits on the dollar

1 amount of essential health benefits.

2 **SECTION 10.** ORS 743B.104 is amended to read:

3 743B.104. (1) Except in the case of a late enrollee and as otherwise provided in this section, a
4 carrier offering a group health benefit plan to a group of two or more prospective certificate holders
5 shall not decline to offer coverage to any eligible prospective enrollee and shall not impose different
6 terms or conditions on the coverage, premiums or contributions of any enrollee in the group that
7 are based on the actual or expected health status, **age, expected length of life, present or pre-**
8 **dicted disability, degree of medical dependency or quality of life** of the enrollee.

9 (2) A carrier that elects to discontinue offering all of its group health benefit plans under ORS
10 743B.105 (5)(e), elects to discontinue renewing all such plans or elects to discontinue offering and
11 renewing all such plans is prohibited from offering health benefit plans in the group market in this
12 state for a period of five years from one of the following dates:

13 (a) The date of notice to the Director of the Department of Consumer and Business Services
14 pursuant to ORS 743B.105 (5)(e); or

15 (b) If notice is not provided under paragraph (a) of this subsection, from the date on which the
16 director provides notice to the carrier that the director has determined that the carrier has effec-
17 tively discontinued offering group health benefit plans in this state.

18 (3) Subsection (1) of this section applies only to group health benefit plans that are not small
19 employer health benefit plans.

20 (4) Nothing in this section shall prohibit an employer from providing different group health
21 benefit plans to various categories of employees as defined by the employer nor prohibit an employer
22 from providing health benefit plans through different carriers so long as the employer's categories
23 of employees are established in a manner that does not relate to the actual or expected health
24 status, **age, expected length of life, present or predicted disability, degree of medical depend-**
25 **ency or quality of life** of the employees or their dependents.

26 (5) A multiple employer welfare arrangement, professional or trade association, or other similar
27 arrangement established or maintained to provide benefits to a particular trade, business, profession
28 or industry or their subsidiaries, shall not issue coverage to a group or individual that is not in the
29 same trade, business, profession or industry or their subsidiaries as that covered by the arrange-
30 ment. The arrangement shall accept all groups and individuals in the same trade, business, profes-
31 sion or industry or their subsidiaries that apply for coverage under the arrangement and that meet
32 the requirements for membership in the arrangement. For purposes of this subsection, the require-
33 ments for membership in an arrangement shall not include any requirements that relate to the ac-
34 tual or expected health status, **age, expected length of life, present or predicted disability,**
35 **degree of medical dependency or quality of life** of the prospective enrollee.

36 **SECTION 11.** ORS 743B.105 is amended to read:

37 743B.105. The following requirements apply to all group health benefit plans other than small
38 employer health benefit plans covering two or more certificate holders:

39 (1) A carrier offering a group health benefit plan may not decline to offer coverage to any eli-
40 gible prospective enrollee and may not impose different terms or conditions on the coverage, pre-
41 miums or contributions of any enrollee in the group that are based on the actual or expected health
42 status, **age, expected length of life, present or predicted disability, degree of medical depend-**
43 **ency or quality of life** of the enrollee.

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

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

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

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

7 (4)(a) A carrier shall issue to a group any of the carrier's group health benefit plans offered by
8 the carrier for which the group is eligible, if the group applies for the plan, agrees to make the re-
9 quired premium payments and agrees to satisfy the other requirements of the plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

42 (C) Must offer in writing to each policyholder covered by the plan, all other group health benefit
43 plans that the carrier offers in the specified service area. The carrier shall offer the plans at least
44 90 days prior to discontinuation.

45 (g) The carrier discontinues both offering and renewing a group health benefit plan, other than

1 a grandfathered health plan, for all groups in this state or in a specified service area within this
2 state, other than a plan discontinued under paragraph (f) of this subsection.

3 (h) The carrier discontinues both offering and renewing a grandfathered health plan for all
4 groups in this state or in a specified service area within this state, other than a plan discontinued
5 under paragraph (f) of this subsection.

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

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

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

11 (C) Act uniformly without regard to the claims experience of the affected policyholders or the
12 health status, **age, expected length of life, present or predicted disability, degree of medical**
13 **dependency or quality of life** of any current or prospective enrollee.

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

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

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

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

22 (L) In the case of a health benefit plan that is offered in the group market only to one or more
23 bona fide associations, the membership of an employer in the association ceases and the termination
24 of coverage is not related to the health status, **age, expected length of life, present or predicted**
25 **disability, degree of medical dependency or quality of life** of any enrollee.

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

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

30 (a) The enrollee:

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

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

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

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

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

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

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

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

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

1 age; and

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

4 (9) A group health benefit plan may not impose annual or lifetime limits on the dollar amount
5 of essential health benefits.

6 **SECTION 12.** ORS 743B.125 is amended to read:

7 743B.125. (1) With respect to coverage under an individual health benefit plan, a carrier may
8 not impose an individual coverage waiting period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (C) Act uniformly without regard to the claims experience of the affected policyholders or the
16 health status, **age, expected length of life, present or predicted disability, degree of medical**
17 **dependency or quality of life** of any current or prospective enrollee.

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

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

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

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

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

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

32 (6) Notwithstanding any other provision of this section, and subject to the provisions of ORS
33 743B.310 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or
34 a representative of the policyholder:

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

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

38 (7) A carrier that continues to offer coverage in the individual market in this state is not re-
39 quired to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier
40 elects to continue a plan that is closed to new individual policyholders instead of offering alterna-
41 tive coverage in its other individual health benefit plans, the coverage for all existing policyholders
42 in the closed plan is renewable in accordance with subsection (4) of this section.

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

45 (9) A grandfathered health plan may not impose lifetime limits on the dollar amount of essential

1 health benefits.

2 (10) This section does not require a carrier to actively market, offer, issue or accept applications
 3 for:

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

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

8 **SECTION 13.** ORS 743B.126 is amended to read:

9 743B.126. (1) Each carrier shall actively market all individual health benefit plans sold by the
 10 carrier that are not grandfathered health plans.

11 (2) Except as provided in subsection (3) of this section, no carrier or insurance producer shall,
 12 directly or indirectly, discourage an individual from filing an application for coverage because of the
 13 [*health status,*] claims experience, occupation, [*or*] geographic location, **health status, age, ex-**
 14 **pected length of life, present or predicted disability, degree of medical dependency or quality**
 15 **of life** of the individual.

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

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

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

24 (6) A carrier that elects to discontinue offering all of its individual health benefit plans under
 25 ORS 743B.125 (4)(c) or to discontinue both offering and renewing all such plans is prohibited from
 26 offering and renewing health benefit plans in the individual market in this state for a period of five
 27 years from the date of notice to the director pursuant to ORS 743B.125 (4)(c) or, if such notice is
 28 not provided, from the date on which the director provides notice to the carrier that the director
 29 has determined that the carrier has effectively discontinued offering individual health benefit plans
 30 in this state. This subsection does not apply with respect to a health benefit plan discontinued in
 31 a specified service area by a carrier that covers services provided only by a particular organization
 32 of health care providers or only by health care providers who are under contract with the carrier.

33 **SECTION 14. The amendments to ORS 735.500, 743.535, 743B.003, 743B.005, 743B.011,**
 34 **743B.012, 743B.013, 743B.104, 743B.105, 743B.125 and 743B.126 by sections 3 to 13 of this 2016**
 35 **Act apply to medical retainer practices and health benefit plans that are in force on or after**
 36 **January 2, 2017.**

37 **SECTION 15. This 2016 Act being necessary for the immediate preservation of the public**
 38 **peace, health and safety, an emergency is declared to exist, and this 2016 Act takes effect**
 39 **on its passage.**