A-Engrossed
House Bill 2387

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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.

Creates Oregon Premium Protection Program in Department of Consumer and Business Services and establishes Oregon Premium Protection Fund. Requires pharmaceutical manufacturer to [*reimburse payers for*] **pay to department** cost of prescription drug that exceeds specified threshold. **Requires department to use payments to reimburse insurers, third party administrators, Public Employees' Benefit Board, Oregon Educators Benefit Board, health care service contractors and multiple employer welfare arrangements for incurred costs of drug that exceeds specified threshold.**

Requires pharmaceutical manufacturer to provide 60 days' advance notice of increase in cost of prescription drug that exceeds 3.4 percent over 12-month period.

Prohibits Public Employees' Benefit Board, Oregon Educators Benefit Board, health care service contractors, multiple employer welfare arrangements and carriers for small employer, group or individual health benefit plans from requiring enrollees to incur out-of-pocket costs for prescription drugs that exceed specified maximums.

Requires pharmaceutical manufacturers to report to Department of Consumer and Business Services specified information about prescription drug costs and about patient assistance programs. Authorizes civil penalties for failing to report **or to make payments required by Oregon Premium Protection Program**.

Requires Public Employees' Benefit Board, Oregon Educators Benefit Board, health care service contractors, multiple employer welfare arrangements and carriers for small employer, group or individual health benefit plans to make available online specified information about prescription drug coverage and costs **and to post to website 30 days' advance notice of termination of coverage of prescription drug**.

[*Requires Public Employees' Benefit Board, Oregon Educators Benefit Board, health care service contractors, multiple employer welfare arrangements and carriers for small employer, group or individual health benefit plans to offer at least one health benefit plan that has no deductible or coinsurance requirement for prescription drugs.*]

A BILL FOR AN ACT

Relating to prescription drugs; creating new provisions; and amending ORS 243.135, 243.866, 743B.013, 743B.105, 743B.125, 750.055 and 750.333.

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

PRESCRIPTION DRUG COSTS

SECTION 1. As used in sections 1 to 4 of this 2017 Act:

(1) "Drug" has the meaning given that term in ORS 689.005.

(2) "Enrollee" has the meaning given that term in section 5 of this 2017 Act.

(3) "Excess cost" means:

(a) For a brand name prescription drug, the difference between the wholesale acquisition cost of the prescription drug and the foreign price cap for the prescription drug only if the

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.

drug:

(A) Has been approved by the United States Food and Drug Administration for longer than 24 months; and

(B) Has a wholesale acquisition cost that is greater than:

(i) The foreign price cap; and

(ii) $12,000.

(b) For a generic, biosimilar or off-patent prescription drug, the amount of any cumulative increase in the wholesale acquisition cost of the drug that exceeds 3.4 percent over a 12-month period.

(4) "Foreign price cap" means the median of the five highest prices paid for a prescription drug in any country other than the United States that is:

(a) A member of the Organisation for Economic Co-operation and Development; or

(b) One of 35 economically developed countries specified by the Department of Consumer and Business Services by rule, if the Organisation for Economic Co-operation and Development ceases to exist.

(5) "Health care practitioner" means an individual or entity that is licensed, certified or registered in this state to provide health care, including by dispensing prescription drugs.

(6)(a) "Manufacture" means:

(A) The production, preparation, propagation, compounding, conversion or processing of a drug, either directly or indirectly by extraction from substances of natural origin or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; and

(B) The packaging or repackaging of a drug or labeling or relabeling of a drug container.

(b) "Manufacture" does not include the preparation or compounding of a drug by an individual for the individual's own use or the preparation, compounding, packaging or labeling of a drug:

(A) By a health care practitioner incidental to administering or dispensing a drug in the course of professional practice;

(B) By a health care practitioner or at the practitioner's authorization and supervision for the purpose of or incidental to research, teaching or chemical analysis activities and not for sale:

(C) By a health care service contractor, as defined in ORS 750.005, for dispensing to a subscriber; or

(D) By a health care facility, as defined in ORS 442.015, for dispensing to a patient of the health care facility.

(7) "Manufacturer" means a person that manufactures a prescription drug that is sold in this state.

(8) "Off-patent" means any drug for which all exclusive marketing rights, if any, granted under the Federal Food, Drug and Cosmetic Act and federal patent law have expired.

(9) "Payer" has the meaning given that term in section 5 of this 2017 Act.

(10) "Plan" has the meaning given that term in section 5 of this 2017 Act.

(11) "Prescription drug" means a drug that must:

(a) Under federal law, be labeled "Caution: Federal law prohibits dispensing without prescription" prior to being dispensed or delivered; or

(b) Under any applicable federal or state law or regulation, be dispensed only by pre-

scription or that is restricted to use only by health care practitioners.

(12) "Wholesale acquisition cost" has the meaning given that term in 42 U.S.C. 1395w-3a(c)(6)(B).

SECTION 2. (1) The Oregon Premium Protection Program is created in the Department of Consumer and Business Services. The purpose of the program is to reduce the burden on consumers and insurers in this state of the excessive costs of prescription drugs.

(2) The department shall prescribe by rule a formula to determine the excess costs incurred by a payer calculated as a percentage of a payer's premium revenue and based on the utilization by the payer's enrollees of drugs that are subject to the excess costs calculation. Payers shall submit claims for rebates of the excess costs to the department in the form and manner prescribed by the department and shall provide supporting data or documentation that the department deems necessary to validate the accuracy of the claims.

(3)(a) The department shall adopt by rule a method for determining the amount of rebates owed by a manufacturer based on claims for rebates of excess costs submitted by payers under subsection (2) of this section.

(b) The department shall charge to and collect from manufacturers the amount of rebates owed, as determined under this subsection.

(4) A payer or a manufacturer may appeal a determination made by the department under subsection (2) or (3) of this section by requesting a contested case hearing in accordance with ORS chapter 183.

(5) The department shall take into account any rebates paid under this section in determining whether an insurer's premium rates meet the requirements of ORS 743.018 (4).

(6) Subsections (3) and (4) of this section do not apply to core antiretroviral therapeutics listed by the United States Secretary of Health and Human Services in accordance with 42 U.S.C. 300ff-26(e) and prescribed for individuals participating in the Aids Drug Assistance Program authorized by 42 U.S.C. 300ff-26.

(7) A manufacturer shall provide advance written notice to payers not less than 60 days prior to the effective date of an increase in the wholesale acquisition cost of a prescription drug that results in a cumulative increase of more than 3.4 percent in the price of the prescription drug over the 12-month period immediately preceding the effective date of the increase.

SECTION 3. (1) The Department of Consumer and Business Services, in carrying out the provisions of sections 1 to 4 of this 2017 Act, shall have the power to:

(a) Administer oaths and affirmations;

(b) Subpoena witnesses;

(c) Compel witnesses to testify under oath; and

(d) Subpoena the production of books, papers, correspondence, memoranda, agreements or other documents or records that the department considers relevant or material to the inquiry.

(2) Each witness who appears before the department under a subpoena shall receive the fees and mileage provided for witnesses under ORS 44.415 (2).

(3) If a person fails to comply with a subpoena or a party or witness refuses to testify on any matters, the judge of the circuit court for any county, on the application of the department, shall compel obedience by proceedings for contempt as in the case of disobedience of the requirements of a subpoena issued from the court or a refusal to testify in the court.

SECTION 4. (1) The Oregon Premium Protection Fund is established in the State Treasury, separate and distinct from the General Fund. The Oregon Premium Protection Fund consists of moneys paid to the Department of Consumer and Business Services by manufacturers under section 2 of this 2017 Act.

(2) Moneys in the Oregon Premium Protection Fund are continuously appropriated to the department for the purposes of:

(a) Reimbursing payers for excess costs in accordance with section 2 of this 2017 Act; and

(b) Administering the Oregon Premium Protection Program created in section 2 of this 2017 Act.

LIMITS ON CONSUMERS' OUT-OF-POCKET COSTS

SECTION 5. (1) As used in this section:

(a) "Enrollee" means an individual whose prescription drug costs are paid or reimbursed, in whole or in part, by a payer.

(b) "Payer" means:

(A) A person with a certificate of authority to transact insurance in this state that offers a health benefit plan as defined in ORS 743B.005;

(B) A person that contracts with a third party administrator or a pharmacy benefit manager to reimburse the cost of a prescription drug prescribed for a resident of this state;

(C) The Public Employees' Benefit Board with respect to employees in a self-insured health benefit plan offered by the board;

(D) The Oregon Educators Benefit Board with respect to employees in a self-insured health benefit plan offered by the board;

(E) A health care service contractor as defined in ORS 750.005; or

(F) A multiple employer welfare arrangement as defined in ORS 750.301.

(c) "Plan" means the terms and conditions for the reimbursement of health care costs by a payer.

(d) "Prescription drug" has the meaning given that term in section 1 of this 2017 Act.

(e) "Prescription drug cost cap" means the total out-of-pocket cost incurred by an enrollee when filling or refilling a covered prescription drug, including copayments, deductibles and coinsurance.

(2) Unless otherwise provided by law, the prescription drug cost cap that a payer may require an enrollee to pay is:

(a) $200 for bronze plans; and

(b) $100 for silver, gold or platinum plans.

(3) The prescription drug cost caps specified in subsection (2) of this section apply only to prescription drugs that are reimbursed by a plan as a pharmacy benefit.

REPORTING OF COST BASIS AND PATIENT ASSISTANCE PROGRAMS

SECTION 6. (1) As used in this section:

(a) "Manufacturer" has the meaning given that term in section 1 of this 2017 Act.

(b) "Patient assistance program" means a program offered to the general public by a

manufacturer in which a patient may, using coupons, discount cards or other means, reduce the patient's out-of-pocket costs for prescription drugs.

(c) "Prescription drug" has the meaning given that term in section 1 of this 2017 Act.

(d) "Wholesale acquisition cost" has the meaning given that term in 42 U.S.C. 1395w-3a(c)(6)(B).

(2) A manufacturer shall report to the Department of Consumer and Business Services, in the form and manner prescribed by the department:

(a) Not later than 30 days after the United States Food and Drug Administration has approved for marketing a prescription drug with an introductory wholesale acquisition cost of $12,000 or more per year:

(A) The justification for the introductory wholesale acquisition cost, including:

(i) A detailed explanation of all major costs associated with the development of the prescription drug, including basic research, costs of each phase of the clinical trial and the capital investment;

(ii) The cost of manufacturing the prescription drug;

(iii) The cost of ongoing safety and effectiveness research associated with the prescription drug;

(iv) The manufacturer's profit margin target for the prescription drug and a detailed explanation of the manufacturer's decision to target that profit margin; and

(v) The manufacturer's anticipated 10-year return on investment in the prescription drug.

(B) The expected marketing budget for the prescription drug, including:

(i) The budget for marketing directly to consumers with advertising;

(ii) The budget for marketing directly to health care providers, including but not limited to outreach conducted by sales representatives, free samples, branded gifts to providers and hosting conferences and other events; and

(iii) A detailed description of the manufacturer's efforts to ensure that the manufacturer's marketing does not encourage prescribing the drug for uses other than those uses approved by the United States Food and Drug Administration or other inappropriate uses.

(C) If the prescription drug was not developed by the manufacturer, any amount paid by the manufacturer to the developer of the drug.

(b) At least annually, for any prescription drug for which the price increased more than 3.4 percent over a 12-month period, the justification for the increase in price. The department shall prescribe by rule the justification factors that must be reported, which may include one or more of the factors described in paragraph (a) of this section.

(c) At least annually, for each prescription drug described in paragraph (a) or (b) of this subsection, the 10 highest prices paid for the drug in the countries for which the foreign price cap for the drug is calculated under section 1 (4) of this 2017 Act.

(3) A manufacturer shall report to the department, in the form and manner prescribed by the department, on the use by residents of this state of the patient assistance programs offered by the manufacturer. The report must include, but is not limited to, all of the following for a 12-month period specified by the department:

(a) The number of residents who participated in each program;

(b) The net cost of each drug dispensed to the residents participating in each program;

(c) The number of refills for each drug that qualify for the patient assistance program or, if the program expires after a specified period of time, the period of time that the program is available to each patient;

(d) The brand name drugs included in each patient assistance program and the number of brand name drugs included in the patient assistance program for which a generic or lower cost alternative drug is available;

(e) Whether mail order pharmacies accept the coupon, discount card or other form of patient assistance provided in each program;

(f) The reduction in the total cost of the manufacturer's prescription drugs sold to residents in this state who participated in the program; and

(g) The reduction in the total cost of the manufacturer's prescription drugs sold to residents in this state participating in each program, expressed as a percentage of the manufacturer's total sales revenue for prescription drugs sold to residents in this state.

(4)(a) After receiving the reports described in subsections (2) and (3) of this section, the department may make a written request to the reporting manufacturer for additional information regarding the content of a report. The department shall prescribe by rule the period:

(A) Following the receipt of a report during which the department may request additional information; and

(B) Following a department request for additional information, during which a manufacturer may respond to the request.

(b) The department may extend the period prescribed under paragraph (a)(B) of this section if the request for additional information is unusually complex or time-consuming for the manufacturer to fulfill.

(5) A manufacturer that fails to respond to a written request for additional information under subsection (4) of this section in a timely manner or that provides inaccurate or incomplete information may be subject to a civil penalty as provided in section 7 of this 2017 Act.

(6) The department shall post on its website all of the following, except for information that is likely to compromise the financial or competitive position of the manufacturer:

(a) The information described in subsections (2) and (3) of this section;

(b) Any written request for additional information made by the department to a manufacturer under subsection (4) of this section; and

(c) All materials received by the department in response to a written request for additional information under subsection (4) of this section.

(7) To the extent that the material described in subsection (2) of this section, or any portion of the material, would otherwise qualify as a trade secret under ORS 192.501, the action taken by the department or any expert or consultant employed by the department in reviewing the material does not affect the status of the material as a trade secret.

(8) The department may adopt rules as necessary for carrying out the provisions of this section.

SECTION 7. (1) A manufacturer that fails to make a payment in accordance with sections 1 to 4 of this 2017 Act or to report or produce documentation in accordance with section 6 of this 2017 Act may be subject to a civil penalty as provided in this section.

(2) The Department of Consumer and Business Services shall adopt a schedule of penalties, not to exceed $_____ per day of violation, based on the severity of each violation.

(3) The department shall impose civil penalties under this section as provided in ORS 183.745.

(4) The department may remit or mitigate civil penalties under this section upon terms and conditions the department considers proper and consistent with the public health and safety.

(5) Civil penalties collected under this section shall be paid over to the State Treasurer and deposited in the General Fund to be made available for general governmental expenses.

CONSUMER EDUCATION ABOUT PRESCRIPTION DRUG COVERAGE

SECTION 8. Section 9 of this 2017 Act is added to and made a part of the Insurance Code.

SECTION 9. (1) As used in this section, "insurer" means a:

(a) Person with a certificate of authority to transact insurance in this state that offers a health benefit plan as defined in ORS 743B.005;

(b) Pharmacy benefit manager as defined in ORS 735.530;

(c) Third party administrator licensed under ORS 744.702;

(d) Health care service contractor as defined in ORS 750.005; or

(e) Multiple employer welfare arrangement as defined in ORS 750.301.

(2) An insurer shall make available on its website, and in writing upon request by an enrollee or potential enrollee, an explanation of how an enrollee can request coverage for a prescription drug that is not on the insurer's drug formulary.

(3) No less than 30 days prior to removing a prescription drug from a drug formulary, an insurer shall post a notice of the intended removal on its website.

(4) Notwithstanding subsection (3) of this section, an insurer shall post a notice on its website informing the public about the removal of a prescription drug from the insurer's drug formulary as soon as practicable and without unreasonable delay if:

(a) The drug is no longer available on the market;

(b) The drug becomes available without a prescription;

(c) The United States Food and Drug Administration issues a boxed warning concerning the drug because of serious or life-threatening risks to individuals taking the drug; or

(d) A generic substitute for the drug becomes available.

PUBLIC EMPLOYEES' BENEFIT BOARD

SECTION 10. ORS 243.135, as amended by section 4, chapter 389, Oregon Laws 2015, is amended to read:

243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees, the state and the local governments. In considering whether to enter into a contract for a plan, the board shall place emphasis on:

(a) Employee choice among high quality plans;

(b) A competitive marketplace;

(c) Plan performance and information;

(d) Employer flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

(g) Plan benefits as part of total employee compensation;

(h) The improvement of employee health; and

(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan.

(2) The board may approve more than one carrier for each type of plan contracted for and offered but the number of carriers shall be held to a number consistent with adequate service to eligible employees and their family members.

(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members.

(4) Payroll deductions for costs that are not payable by the state or a local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

(5) In developing any health benefit plan, the board may provide an option of additional coverage for eligible employees and their family members at an additional cost or premium.

(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and their family members under rules adopted by the board. Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

(7) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

(8) Health benefit plans offered by the board may not require eligible employees and their family members to incur out-of-pocket costs that exceed the prescription drug cost cap specified in section 5 of this 2017 Act.

(9) The board or an insurer offering a health benefit plan to eligible employees shall make available online, and in writing upon request by an eligible employee, an explanation of how an eligible employee or family member can request coverage for a prescription drug that is not on the health benefit plan's drug formulary.

(10) No less than 30 days prior to removing a prescription drug from a drug formulary, the board or the insurer shall post a notice of the intended removal on its website.

(11) Notwithstanding subsection (10) of this section, the board or an insurer shall post a notice on its website informing the public about the removal of a prescription drug from the health benefit plan's drug formulary as soon as practicable and without unreasonable delay if:

(a) The drug is no longer available on the market;

(b) The drug becomes available without a prescription;

(c) The United States Food and Drug Administration issues a boxed warning concerning the drug because of serious or life-threatening risks to individuals taking the drug; or

(d) A generic substitute for the drug becomes available.

OREGON EDUCATORS BENEFIT BOARD

SECTION 11. ORS 243.866, as amended by section 5, chapter 389, Oregon Laws 2015, is amended to read:

243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed to meet the needs and provide for the welfare of eligible employees, the districts and local governments. In considering whether to enter into a contract for a benefit plan, the board shall place emphasis on:

(a) Employee choice among high-quality plans;

(b) Encouragement of a competitive marketplace;

(c) Plan performance and information;

(d) District and local government flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

(g) Plan benefits as part of total employee compensation;

(h) Improvement of employee health; and

(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan.

(2) The board may approve more than one carrier for each type of benefit plan offered, but the board shall limit the number of carriers to a number consistent with adequate service to eligible employees and family members.

(3) When appropriate, the board shall provide options under which an eligible employee may arrange coverage for family members under a benefit plan.

(4) A district or a local government shall provide that payroll deductions for benefit plan costs that are not payable by the district or local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the benefit plan or plans selected and allowing the deduction of those costs from the employee's pay.

(5) In developing any benefit plan, the board may provide an option of additional coverage for eligible employees and family members at an additional premium.

(6) The board shall adopt rules providing that transfer of enrollment from one benefit plan to another is open to all eligible employees and family members. Because of the special problems that may arise involving acceptable provider-patient relations between a particular panel of providers and a particular eligible employee or family member under a comprehensive group practice benefit plan, the board shall provide a procedure under which any eligible employee may apply at any time to substitute another benefit plan for participation in a comprehensive group practice benefit plan.

(7) An eligible employee who is retired is not required to participate in a health benefit plan offered under this section in order to obtain dental benefit plan coverage. The board shall establish by rule standards of eligibility for retired employees to participate in a dental benefit plan.

(8) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

(9) Health benefit plans offered by the board may not require eligible employees and their family members to incur out-of-pocket costs that exceed the prescription drug cost cap specified in section 2 of this 2017 Act.

(10) The board or an insurer offering a health benefit plan to eligible employees shall make available online, and in writing upon request by an eligible employee, an explanation of how an eligible employee or family member can request coverage for a prescription drug that is not on the health benefit plan's drug formulary.

(11) No less than 30 days prior to removing a prescription drug from a drug formulary, the board or the insurer shall post a notice of the intended removal on its website.

(12) Notwithstanding subsection (11) of this section, the board or an insurer shall post a notice on its website informing the public about the removal of a prescription drug from the health benefit plan's drug formulary as soon as practicable and without unreasonable delay if:

(a) The drug is no longer available on the market;

(b) The drug becomes available without a prescription;

(c) The United States Food and Drug Administration issues a boxed warning concerning the drug because of serious or life-threatening risks to individuals taking the drug; or

(d) A generic substitute for the drug becomes available.

SMALL EMPLOYER HEALTH BENEFIT PLANS

SECTION 12. ORS 743B.013 is amended to read:

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

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

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

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

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

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

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

(b) The policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

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

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

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

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

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

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

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

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

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

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

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

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

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

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

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

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

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

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

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

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

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

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

(iii) Adjustments to reflect differences in family composition.

(C) A carrier shall apply the carrier's schedule of premium rate variations as approved by the

department and in accordance with this paragraph. Except as otherwise provided in this section, the premium rate established by a carrier for a small employer health benefit plan shall apply uniformly to all employees of the small employer enrolled in that plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(17) An enrollee in a small employer health benefit plan that reimburses the costs of prescription drugs, other than a grandfathered health plan, may not incur out-of-pocket costs for a covered drug that exceed the prescription drug cost cap specified in section 5 of this 2017 Act.

GROUP HEALTH BENEFIT PLANS

SECTION 13. ORS 743B.105 is amended to read:

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

(1) A carrier offering a group health benefit plan may not decline to offer coverage to any eligible prospective enrollee and may not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

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

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

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

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

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

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

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

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

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

(c) The number of enrollees covered under the plan is less than the number or percentage of

enrollees required by participation requirements under the plan.

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

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

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

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

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

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

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

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

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

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

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

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

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

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

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

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

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

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

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

service area of the provider network.

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

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

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

(a) The enrollee:

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

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

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

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

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

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

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

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

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

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

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

(10) An enrollee in a group health benefit plan that reimburses the costs of prescription drugs, other than a grandfathered health plan, may not incur out-of-pocket costs for a covered drug that exceed the prescription drug cost cap specified in section 5 of this 2017 Act.

INDIVIDUAL HEALTH BENEFIT PLANS

SECTION 14. ORS 743B.125 is amended to read:

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

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

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

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

(A) The exclusion applies only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the

individual's effective date of coverage.

(B) The exclusion expires no later than six months after the individual's effective date of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) With respect to plans that are being discontinued under paragraph (e) or (f) of this subsection, the carrier must:

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

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

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

health status of any current or prospective enrollee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) A policyholder of an individual health benefit plan that reimburses the costs of prescription drugs may not incur out-of-pocket costs for a covered drug that exceed the prescription drug cost cap specified in section 5 of this 2017 Act.

HEALTH CARE SERVICE CONTRACTORS

SECTION 15. ORS 750.055, as amended by section 7, chapter 59, Oregon Laws 2015, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service con-

tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743A.252.

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

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

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

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800 and section 2, chapter 771, Oregon Laws 2013**, and section 5 of this 2017 Act**.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

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

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

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

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

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

SECTION 16. ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section 6, chapter 25, Oregon Laws 2014, section 81, chapter 45, Oregon Laws 2014, section 8, chapter 59, Oregon Laws 2015, section 6, chapter 100, Oregon Laws 2015, section 6, chapter 224, Oregon Laws

2015, section 10, chapter 362, Oregon Laws 2015, section 9, chapter 470, Oregon Laws 2015, and section 29, chapter 515, Oregon Laws 2015, is amended to read:

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

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743A.252.

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

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

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

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800 and section 2, chapter 771, Oregon Laws 2013**, and section 5 of this 2017 Act**.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

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

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

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

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

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

SECTION 17. ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59, Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, and section 30, chapter 515, Oregon Laws 2015, is amended to read:

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

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743A.252.

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

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

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

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800 **and section 5 of this 2017 Act**.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

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

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

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

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

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

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

SECTION 18. ORS 750.333, as amended by section 10, chapter 59, Oregon Laws 2015, is amended to read:

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

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 to 731.992, 743.029 and 743A.252.

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

(c) ORS chapter 734.

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

(e) ORS 743.004, 743.008, 743.028, 743.053, 743.406, 743.524, 743.526, 743.528, 743.535, 743A.012, 743A.020, 743A.034, 743A.051, 743A.052, 743A.064, 743A.065, 743A.080, 743A.082, 743A.100, 743A.104, 743A.110, 743A.144, 743A.150, 743A.170, 743A.175, 743A.184, 743A.192, 743A.250, 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555 and 743B.601.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048, 743A.058, 743A.066, 743A.068, 743A.070, 743A.084, 743A.088, 743A.090, 743A.105, 743A.140, 743A.141, 743A.148, 743A.168, 743A.180, 743A.185, 743A.188 and 743A.190. Multiple employer welfare arrangements to which ORS 743.004, 743.022, 743.535 and 743B.003 to 743B.127 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.004, 743.022, 743.535 and 743B.003 to 743B.127.

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

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

(i) ORS 731.592 and 731.594.

(j) ORS 731.870.

(k) Section 5 of this 2017 Act.

(2) For the purposes of this section:

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

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

(c) Contributions shall be considered premiums.

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

APPLICABILITY

SECTION 19. Notwithstanding the deadline imposed under section 6 (2)(a) of this 2017 Act, a manufacturer shall report as required under section 6 (2)(a) of this 2017 Act, by a date designated by the Department of Consumer and Business Services by rule, with respect to any prescription drug approved by the United States Food and Drug Administration before the effective date of this 2017 Act that has a wholesale acquisition cost, as defined in section 1 of this 2017 Act, of $12,000 or more on the effective date of this 2017 Act.

SECTION 20. Section 5 of this 2017 Act and the amendments to ORS 743B.013, 743B.105, 743B.125, 750.055 and 750.333 by sections 12 to 18 of this 2017 Act apply to health benefit plans for which a carrier, on the effective date of this 2017 Act, has not filed rates with the Department of Consumer and Business Services for approval under ORS 743.018.

NONSEVERABILITY

SECTION 21. It is the intent of the Legislative Assembly that sections 1 to 9 of this 2017 Act and the amendments to ORS 243.135, 243.866, 743B.013, 743B.105, 743B.125, 750.055 and 750.333 by sections 10 to 18 of this 2017 Act are essentially and inseparably connected with and dependent upon each other. The Legislative Assembly does not intend that sections 1 to 9 of this 2017 Act and the amendments to ORS 243.135, 243.866, 743B.013, 743B.105, 743B.125, 750.055 and 750.333 by sections 10 to 18 of this 2017 Act be the law if any of those sections or amendments to statutes are held unconstitutional.

UNIT CAPTIONS

SECTION 22. The unit captions used in this 2017 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2017 Act.