

House Bill 2703

Sponsored by Representative NOSSE (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**.

Requires Department of Consumer and Business Services to adopt rules concerning sale of short term health insurance policies with terms of 12 months or less. Specifies requirements.
Sunsets December 31, 2021.

A BILL FOR AN ACT

1
2 Relating to short term health insurance policies; creating new provisions; and amending ORS
3 192.556, 743B.005 and 746.600.

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

5 **SECTION 1. Section 2 of this 2019 Act is added to and made a part of the Insurance Code.**

6 **SECTION 2. The Department of Consumer and Business Services shall adopt by rule re-**
7 **quirements for offering, in this state, short term health insurance policies. The requirements**
8 **must include that:**

9 (1) **A short term health insurance policy:**

10 (a) **May not be in effect for more than 12 months in each 36-month period and may not**
11 **be renewed; and**

12 (b) **Expires on December 31 of the year the policy is issued regardless of the date the**
13 **policy is sold.**

14 (2) **A broker selling a short term health insurance policy:**

15 (a) **Must first complete a certification training approved by the department; and**

16 (b) **Shall be paid a one-time finder's fee of \$75 for enrolling an individual in a short term**
17 **health insurance policy.**

18 **SECTION 3. ORS 743B.005 is amended to read:**

19 743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and
20 743B.128:

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

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

31 (3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health

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 care service contractor, a period:

2 (a) That is applied uniformly and without regard to any health status related factors to an
3 enrollee or late enrollee;

4 (b) That must expire before any coverage becomes effective under the plan for the enrollee or
5 late enrollee;

6 (c) During which no premium shall be charged to the enrollee or late enrollee; and

7 (d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs
8 concurrently with any eligibility waiting period under the plan.

9 (4) "Bona fide association" means an association that:

10 (a) Has been in active existence for at least five years;

11 (b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

12 (c) Does not condition membership in the association on any factor relating to the health status
13 of an individual or the individual's dependent or employee;

14 (d) Makes health insurance coverage that is offered through the association available to all
15 members of the association regardless of the health status of the member or individuals who are
16 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 rule by the United States Sec-
 10 retaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) that
 11 is in effect on January 1, 2017.

12 (15) "Group eligibility waiting period" means, with respect to a group health benefit plan, the
 13 period of employment or membership with the group that a prospective enrollee must complete be-
 14 fore plan coverage begins.

15 (16)(a) "Health benefit plan" means any:

16 (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

17 (B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or

18 (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-
 19 ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the
 20 extent that the plan is subject to state regulation.

21 (b) "Health benefit plan" does not include:

22 (A) Coverage for accident only, specific disease or condition only, credit or disability income;

23 (B) Coverage of Medicare services pursuant to contracts with the federal government;

24 (C) Medicare supplement insurance policies;

25 (D) Coverage of TRICARE services pursuant to contracts with the federal government;

26 (E) Benefits delivered through a flexible spending arrangement established pursuant to section
 27 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition
 28 to a group health benefit plan;

29 (F) Separately offered long term care insurance, including, but not limited to, coverage of nurs-
 30 ing home care, home health care and community-based care;

31 (G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity in-
 32 surance;

33 (H) Short term health insurance policies [*that are in effect for periods of three months or less,*
 34 *including the term of a renewal of the policy*];

35 (I) Dental only coverage;

36 (J) Vision only coverage;

37 (K) Stop-loss coverage that meets the requirements of ORS 742.065;

38 (L) Coverage issued as a supplement to liability insurance;

39 (M) Insurance arising out of a workers' compensation or similar law;

40 (N) Automobile medical payment insurance or insurance under which benefits are payable with
 41 or without regard to fault and that is statutorily required to be contained in any liability insurance
 42 policy or equivalent self-insurance; or

43 (O) Any employee welfare benefit plan that is exempt from state regulation because of the fed-
 44 eral Employee Retirement Income Security Act of 1974, as amended.

45 [*c) For purposes of this subsection, renewal of a short term health insurance policy includes the*

1 *issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days*
 2 *after the expiration of a policy previously issued by the insurer to the policyholder.]*

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

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

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

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

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

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

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

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

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

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

24 (20) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement
 25 as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended,
 26 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

27 (21) "Preexisting condition exclusion" means:

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

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

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

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

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

45 (25) "Small employer" means an employer who employed an average of at least one but not more

1 than 50 full-time equivalent employees on business days during the preceding calendar year and who
 2 employs at least one full-time equivalent employee on the first day of the plan year, determined in
 3 accordance with a methodology prescribed by the Department of Consumer and Business Services
 4 by rule.

5 **SECTION 4.** ORS 746.600 is amended to read:

6 746.600. As used in ORS 746.600 to 746.690:

7 (1)(a) “Adverse underwriting decision” means any of the following actions with respect to in-
 8 surance transactions involving insurance coverage that is individually underwritten:

9 (A) A declination of insurance coverage.

10 (B) A termination of insurance coverage.

11 (C) Failure of an insurance producer to apply for insurance coverage with a specific insurer that
 12 the insurance producer represents and that is requested by an applicant.

13 (D) In the case of life or health insurance coverage, an offer to insure at higher than standard
 14 rates.

15 (E) In the case of insurance coverage other than life or health insurance coverage:

16 (i) Placement by an insurer or insurance producer of a risk with a residual market mechanism,
 17 an unauthorized insurer or an insurer that specializes in substandard risks.

18 (ii) The charging of a higher rate on the basis of information that differs from that which the
 19 applicant or policyholder furnished.

20 (iii) An increase in any charge imposed by the insurer for any personal insurance in connection
 21 with the underwriting of insurance. For purposes of this sub-subparagraph, the imposition of a ser-
 22 vice fee is not a charge.

23 (b) “Adverse underwriting decision” does not mean any of the following actions, but the insurer
 24 or insurance producer responsible for the occurrence of the action must nevertheless provide the
 25 applicant or policyholder with the specific reason or reasons for the occurrence:

26 (A) The termination of an individual policy form on a class or statewide basis.

27 (B) A declination of insurance coverage solely because the coverage is not available on a class
 28 or statewide basis.

29 (C) The rescission of a policy.

30 (2) “Affiliate of” a specified person or “person affiliated with” a specified person means a person
 31 who directly, or indirectly, through one or more intermediaries, controls, or is controlled by, or is
 32 under common control with, the person specified.

33 (3) “Applicant” means a person who seeks to contract for insurance coverage, other than a
 34 person seeking group insurance coverage that is not individually underwritten.

35 (4) “Consumer” means an individual, or the personal representative of the individual, who seeks
 36 to obtain, obtains or has obtained one or more insurance products or services from a licensee that
 37 are to be used primarily for personal, family or household purposes, and about whom the licensee
 38 has personal information.

39 (5) “Consumer report” means any written, oral or other communication of information bearing
 40 on a natural person’s creditworthiness, credit standing, credit capacity, character, general reputa-
 41 tion, personal characteristics or mode of living that is used or expected to be used in connection
 42 with an insurance transaction.

43 (6) “Consumer reporting agency” means a person that, for monetary fees or dues, or on a co-
 44 operative or nonprofit basis:

45 (a) Regularly engages, in whole or in part, in assembling or preparing consumer reports;

1 (b) Obtains information primarily from sources other than insurers; and

2 (c) Furnishes consumer reports to other persons.

3 (7) "Control" means, and the terms "controlled by" or "under common control with" refer to,
4 the possession, directly or indirectly, of the power to direct or cause the direction of the manage-
5 ment and policies of a person, whether through the ownership of voting securities, by contract other
6 than a commercial contract for goods or nonmanagement services, or otherwise, unless the power
7 of the person is the result of a corporate office held in, or an official position held with, the con-
8 trolled person.

9 (8) "Covered entity" means:

10 (a) A health insurer;

11 (b) A health care provider that transmits any health information in electronic form to carry out
12 financial or administrative activities in connection with a transaction covered by ORS 746.607 or
13 by rules adopted under ORS 746.608; or

14 (c) A health care clearinghouse.

15 (9) "Credit history" means any written or other communication of any information by a con-
16 sumer reporting agency that:

17 (a) Bears on a consumer's creditworthiness, credit standing or credit capacity; and

18 (b) Is used or expected to be used, or collected in whole or in part, as a factor in determining
19 eligibility, premiums or rates for personal insurance.

20 (10) "Customer" means a consumer who has a continuing relationship with a licensee under
21 which the licensee provides one or more insurance products or services to the consumer that are
22 to be used primarily for personal, family or household purposes.

23 (11) "Declination of insurance coverage" or "decline coverage" means a denial, in whole or in
24 part, by an insurer or insurance producer of an application for requested insurance coverage.

25 (12) "Health care" means care, services or supplies related to the health of an individual.

26 (13) "Health care operations" includes but is not limited to:

27 (a) Quality assessment, accreditation, auditing and improvement activities;

28 (b) Case management and care coordination;

29 (c) Reviewing the competence, qualifications or performance of health care providers or health
30 insurers;

31 (d) Underwriting activities;

32 (e) Arranging for legal services;

33 (f) Business planning;

34 (g) Customer services;

35 (h) Resolving internal grievances;

36 (i) Creating deidentified information; and

37 (j) Fundraising.

38 (14) "Health care provider" includes but is not limited to:

39 (a) A psychologist, occupational therapist, regulated social worker, professional counselor or
40 marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675
41 or an employee of the psychologist, occupational therapist, regulated social worker, professional
42 counselor or marriage and family therapist;

43 (b) A physician or physician assistant licensed under ORS chapter 677, an acupuncturist licensed
44 under ORS 677.759 or an employee of the physician, physician assistant or acupuncturist;

45 (c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of

- 1 the nurse or nursing home administrator;
- 2 (d) A dentist licensed under ORS chapter 679 or an employee of the dentist;
- 3 (e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental
4 hygienist or denturist;
- 5 (f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee
6 of the speech-language pathologist or audiologist;
- 7 (g) An emergency medical services provider licensed under ORS chapter 682;
- 8 (h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;
- 9 (i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic
10 physician;
- 11 (j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic
12 physician;
- 13 (k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage
14 therapist;
- 15 (L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct
16 entry midwife;
- 17 (m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical
18 therapist;
- 19 (n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical
20 imaging licensee;
- 21 (o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory
22 care practitioner;
- 23 (p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the poly-
24 somnographic technologist;
- 25 (q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;
- 26 (r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;
- 27 (s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral
28 service practitioner;
- 29 (t) A health care facility as defined in ORS 442.015;
- 30 (u) A home health agency as defined in ORS 443.014;
- 31 (v) A hospice program as defined in ORS 443.850;
- 32 (w) A clinical laboratory as defined in ORS 438.010;
- 33 (x) A pharmacy as defined in ORS 689.005;
- 34 (y) A diabetes self-management program as defined in ORS 743.694; and
- 35 (z) Any other person or entity that furnishes, bills for or is paid for health care in the normal
36 course of business.
- 37 (15) "Health information" means any oral or written information in any form or medium that:
- 38 (a) Is created or received by a covered entity, a public health authority, a life insurer, a school,
39 a university or a health care provider that is not a covered entity; and
- 40 (b) Relates to:
- 41 (A) The past, present or future physical or mental health or condition of an individual;
- 42 (B) The provision of health care to an individual; or
- 43 (C) The past, present or future payment for the provision of health care to an individual.
- 44 (16) "Health insurer" means an insurer who offers:
- 45 (a) A health benefit plan as defined in ORS 743B.005;

1 (b) A short term health insurance policy[, *the duration of which does not exceed three months*
2 *including renewals*];

3 (c) A student health insurance policy;

4 (d) A Medicare supplemental policy; or

5 (e) A dental only policy.

6 (17) "Homeowner insurance" means insurance for residential property consisting of a combina-
7 tion of property insurance and casualty insurance that provides coverage for the risks of owning
8 or occupying a dwelling and that is not intended to cover an owner's interest in rental property or
9 commercial exposures.

10 (18) "Individual" means a natural person who:

11 (a) In the case of life or health insurance, is a past, present or proposed principal insured or
12 certificate holder;

13 (b) In the case of other kinds of insurance, is a past, present or proposed named insured or
14 certificate holder;

15 (c) Is a past, present or proposed policyowner;

16 (d) Is a past or present applicant;

17 (e) Is a past or present claimant; or

18 (f) Derived, derives or is proposed to derive insurance coverage under an insurance policy or
19 certificate that is subject to ORS 746.600 to 746.690.

20 (19) "Individually identifiable health information" means any oral or written health information
21 that is:

22 (a) Created or received by a covered entity or a health care provider that is not a covered en-
23 tity; and

24 (b) Identifiable to an individual, including demographic information that identifies the individual,
25 or for which there is a reasonable basis to believe the information can be used to identify an indi-
26 vidual, and that relates to:

27 (A) The past, present or future physical or mental health or condition of an individual;

28 (B) The provision of health care to an individual; or

29 (C) The past, present or future payment for the provision of health care to an individual.

30 (20) "Institutional source" means a person or governmental entity that provides information
31 about an individual to an insurer, insurance producer or insurance-support organization, other than:

32 (a) An insurance producer;

33 (b) The individual who is the subject of the information; or

34 (c) A natural person acting in a personal capacity rather than in a business or professional ca-
35 pacity.

36 (21) "Insurance producer" or "producer" means a person licensed by the Director of the De-
37 partment of Consumer and Business Services as a resident or nonresident insurance producer.

38 (22) "Insurance score" means a number or rating that is derived from an algorithm, computer
39 application, model or other process that is based in whole or in part on credit history.

40 (23)(a) "Insurance-support organization" means a person who regularly engages, in whole or in
41 part, in assembling or collecting information about natural persons for the primary purpose of pro-
42 viding the information to an insurer or insurance producer for insurance transactions, including:

43 (A) The furnishing of consumer reports to an insurer or insurance producer for use in con-
44 nection with insurance transactions; and

45 (B) The collection of personal information from insurers, insurance producers or other

1 insurance-support organizations for the purpose of detecting or preventing fraud, material misrep-
 2 resentation or material nondisclosure in connection with insurance underwriting or insurance claim
 3 activity.

4 (b) “Insurance-support organization” does not mean insurers, insurance producers, governmental
 5 institutions or health care providers.

6 (24) “Insurance transaction” means any transaction that involves insurance primarily for per-
 7 sonal, family or household needs rather than business or professional needs and that entails:

8 (a) The determination of an individual’s eligibility for an insurance coverage, benefit or payment;
 9 or

10 (b) The servicing of an insurance application, policy or certificate.

11 (25) “Insurer” has the meaning given that term in ORS 731.106.

12 (26) “Investigative consumer report” means a consumer report, or portion of a consumer report,
 13 for which information about a natural person’s character, general reputation, personal character-
 14 istics or mode of living is obtained through personal interviews with the person’s neighbors, friends,
 15 associates, acquaintances or others who may have knowledge concerning such items of information.

16 (27) “Licensee” means an insurer, insurance producer or other person authorized or required to
 17 be authorized, or licensed or required to be licensed, pursuant to the Insurance Code.

18 (28) “Loss history report” means a report provided by, or a database maintained by, an
 19 insurance-support organization or consumer reporting agency that contains information regarding
 20 the claims history of the individual property that is the subject of the application for a homeowner
 21 insurance policy or the consumer applying for a homeowner insurance policy.

22 (29) “Nonaffiliated third party” means any person except:

23 (a) An affiliate of a licensee;

24 (b) A person that is employed jointly by a licensee and by a person that is not an affiliate of the
 25 licensee; and

26 (c) As designated by the director by rule.

27 (30) “Payment” includes but is not limited to:

28 (a) Efforts to obtain premiums or reimbursement;

29 (b) Determining eligibility or coverage;

30 (c) Billing activities;

31 (d) Claims management;

32 (e) Reviewing health care to determine medical necessity;

33 (f) Utilization review; and

34 (g) Disclosures to consumer reporting agencies.

35 (31)(a) “Personal financial information” means:

36 (A) Information that is identifiable with an individual, gathered in connection with an insurance
 37 transaction from which judgments can be made about the individual’s character, habits, avocations,
 38 finances, occupations, general reputation, credit or any other personal characteristics; or

39 (B) An individual’s name, address and policy number or similar form of access code for the
 40 individual’s policy.

41 (b) “Personal financial information” does not mean information that a licensee has a reasonable
 42 basis to believe is lawfully made available to the general public from federal, state or local gov-
 43 ernment records, widely distributed media or disclosures to the public that are required by federal,
 44 state or local law.

45 (32) “Personal information” means:

- 1 (a) Personal financial information;
2 (b) Individually identifiable health information; or
3 (c) Protected health information.
- 4 (33) "Personal insurance" means the following types of insurance products or services that are
5 to be used primarily for personal, family or household purposes:
6 (a) Private passenger automobile coverage;
7 (b) Homeowner, mobile homeowners, manufactured homeowners, condominium owners and
8 renters coverage;
9 (c) Personal dwelling property coverage;
10 (d) Personal liability and theft coverage, including excess personal liability and theft coverage;
11 and
12 (e) Personal inland marine coverage.
- 13 (34) "Personal representative" includes but is not limited to:
14 (a) A person appointed as a guardian under ORS 125.305, 419B.372, 419C.481 or 419C.555 with
15 authority to make medical and health care decisions;
16 (b) A person appointed as a health care representative under ORS 127.505 to 127.660 or 127.700
17 to 127.737 to make health care decisions or mental health treatment decisions;
18 (c) A person appointed as a personal representative under ORS chapter 113; and
19 (d) A person described in ORS 746.611.
- 20 (35) "Policyholder" means a person who:
21 (a) In the case of individual policies of life or health insurance, is a current policyowner;
22 (b) In the case of individual policies of other kinds of insurance, is currently a named insured;
23 or
24 (c) In the case of group policies of insurance under which coverage is individually underwritten,
25 is a current certificate holder.
- 26 (36) "Pretext interview" means an interview wherein the interviewer, in an attempt to obtain
27 personal information about a natural person, does one or more of the following:
28 (a) Pretends to be someone the interviewer is not.
29 (b) Pretends to represent a person the interviewer is not in fact representing.
30 (c) Misrepresents the true purpose of the interview.
31 (d) Refuses upon request to identify the interviewer.
- 32 (37) "Privileged information" means information that is identifiable with an individual and that:
33 (a) Relates to a claim for insurance benefits or a civil or criminal proceeding involving the in-
34 dividual; and
35 (b) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits
36 or a civil or criminal proceeding involving the individual.
- 37 (38)(a) "Protected health information" means individually identifiable health information that is
38 transmitted or maintained in any form of electronic or other medium by a covered entity.
39 (b) "Protected health information" does not mean individually identifiable health information in:
40 (A) Education records covered by the federal Family Educational Rights and Privacy Act (20
41 U.S.C. 1232g);
42 (B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or
43 (C) Employment records held by a covered entity in its role as employer.
- 44 (39) "Residual market mechanism" means an association, organization or other entity involved
45 in the insuring of risks under ORS 735.005 to 735.145, 737.312 or other provisions of the Insurance

1 Code relating to insurance applicants who are unable to procure insurance through normal insur-
 2 ance markets.

3 (40) "Termination of insurance coverage" or "termination of an insurance policy" means either
 4 a cancellation or a nonrenewal of an insurance policy, in whole or in part, for any reason other than
 5 the failure of a premium to be paid as required by the policy.

6 (41) "Treatment" includes but is not limited to:

- 7 (a) The provision, coordination or management of health care; and
- 8 (b) Consultations and referrals between health care providers.

9 **SECTION 5.** ORS 192.556 is amended to read:

10 192.556. As used in ORS 192.553 to 192.581:

11 (1) "Authorization" means a document written in plain language that contains at least the fol-
 12 lowing:

13 (a) A description of the information to be used or disclosed that identifies the information in a
 14 specific and meaningful way;

15 (b) The name or other specific identification of the person or persons authorized to make the
 16 requested use or disclosure;

17 (c) The name or other specific identification of the person or persons to whom the covered entity
 18 may make the requested use or disclosure;

19 (d) A description of each purpose of the requested use or disclosure, including but not limited
 20 to a statement that the use or disclosure is at the request of the individual;

21 (e) An expiration date or an expiration event that relates to the individual or the purpose of the
 22 use or disclosure;

23 (f) The signature of the individual or personal representative of the individual and the date;

24 (g) A description of the authority of the personal representative, if applicable; and

25 (h) Statements adequate to place the individual on notice of the following:

26 (A) The individual's right to revoke the authorization in writing;

27 (B) The exceptions to the right to revoke the authorization;

28 (C) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits
 29 on whether the individual signs the authorization; and

30 (D) The potential for information disclosed pursuant to the authorization to be subject to
 31 redisclosure by the recipient and no longer protected.

32 (2) "Covered entity" means:

33 (a) A state health plan;

34 (b) A health insurer;

35 (c) A health care provider that transmits any health information in electronic form to carry out
 36 financial or administrative activities in connection with a transaction covered by ORS 192.553 to
 37 192.581; or

38 (d) A health care clearinghouse.

39 (3) "Health care" means care, services or supplies related to the health of an individual.

40 (4) "Health care operations" includes but is not limited to:

41 (a) Quality assessment, accreditation, auditing and improvement activities;

42 (b) Case management and care coordination;

43 (c) Reviewing the competence, qualifications or performance of health care providers or health
 44 insurers;

45 (d) Underwriting activities;

- 1 (e) Arranging for legal services;
- 2 (f) Business planning;
- 3 (g) Customer services;
- 4 (h) Resolving internal grievances;
- 5 (i) Creating deidentified information; and
- 6 (j) Fundraising.
- 7 (5) "Health care provider" includes but is not limited to:
- 8 (a) A psychologist, occupational therapist, regulated social worker, professional counselor or
- 9 marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675
- 10 or an employee of the psychologist, occupational therapist, regulated social worker, professional
- 11 counselor or marriage and family therapist;
- 12 (b) A physician or physician assistant licensed under ORS chapter 677, an acupuncturist licensed
- 13 under ORS 677.759 or an employee of the physician, physician assistant or acupuncturist;
- 14 (c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of
- 15 the nurse or nursing home administrator;
- 16 (d) A dentist licensed under ORS chapter 679 or an employee of the dentist;
- 17 (e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental
- 18 hygienist or denturist;
- 19 (f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee
- 20 of the speech-language pathologist or audiologist;
- 21 (g) An emergency medical services provider licensed under ORS chapter 682;
- 22 (h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;
- 23 (i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic
- 24 physician;
- 25 (j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic
- 26 physician;
- 27 (k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage
- 28 therapist;
- 29 (L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct
- 30 entry midwife;
- 31 (m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical
- 32 therapist;
- 33 (n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical
- 34 imaging licensee;
- 35 (o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory
- 36 care practitioner;
- 37 (p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the poly-
- 38 somnographic technologist;
- 39 (q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;
- 40 (r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;
- 41 (s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral
- 42 service practitioner;
- 43 (t) A health care facility as defined in ORS 442.015;
- 44 (u) A home health agency as defined in ORS 443.014;
- 45 (v) A hospice program as defined in ORS 443.850;

- 1 (w) A clinical laboratory as defined in ORS 438.010;
- 2 (x) A pharmacy as defined in ORS 689.005; and
- 3 (y) Any other person or entity that furnishes, bills for or is paid for health care in the normal
- 4 course of business.
- 5 (6) "Health information" means any oral or written information in any form or medium that:
- 6 (a) Is created or received by a covered entity, a public health authority, an employer, a life
- 7 insurer, a school, a university or a health care provider that is not a covered entity; and
- 8 (b) Relates to:
- 9 (A) The past, present or future physical or mental health or condition of an individual;
- 10 (B) The provision of health care to an individual; or
- 11 (C) The past, present or future payment for the provision of health care to an individual.
- 12 (7) "Health insurer" means an insurer as defined in ORS 731.106 who offers:
- 13 (a) A health benefit plan as defined in ORS 743B.005;
- 14 (b) A short term health insurance policy[, *the duration of which does not exceed three months*
- 15 *including renewals*];
- 16 (c) A student health insurance policy;
- 17 (d) A Medicare supplemental policy; or
- 18 (e) A dental only policy.
- 19 (8) "Individually identifiable health information" means any oral or written health information
- 20 in any form or medium that is:
- 21 (a) Created or received by a covered entity, an employer or a health care provider that is not
- 22 a covered entity; and
- 23 (b) Identifiable to an individual, including demographic information that identifies the individual,
- 24 or for which there is a reasonable basis to believe the information can be used to identify an indi-
- 25 vidual, and that relates to:
- 26 (A) The past, present or future physical or mental health or condition of an individual;
- 27 (B) The provision of health care to an individual; or
- 28 (C) The past, present or future payment for the provision of health care to an individual.
- 29 (9) "Payment" includes but is not limited to:
- 30 (a) Efforts to obtain premiums or reimbursement;
- 31 (b) Determining eligibility or coverage;
- 32 (c) Billing activities;
- 33 (d) Claims management;
- 34 (e) Reviewing health care to determine medical necessity;
- 35 (f) Utilization review; and
- 36 (g) Disclosures to consumer reporting agencies.
- 37 (10) "Personal representative" includes but is not limited to:
- 38 (a) A person appointed as a guardian under ORS 125.305, 419B.372, 419C.481 or 419C.555 with
- 39 authority to make medical and health care decisions;
- 40 (b) A person appointed as a health care representative under ORS 127.505 to 127.660 or a rep-
- 41 resentative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment
- 42 decisions;
- 43 (c) A person appointed as a personal representative under ORS chapter 113; and
- 44 (d) A person described in ORS 192.573.
- 45 (11)(a) "Protected health information" means individually identifiable health information that is

1 maintained or transmitted in any form of electronic or other medium by a covered entity.

2 (b) "Protected health information" does not mean individually identifiable health information in:

3 (A) Education records covered by the federal Family Educational Rights and Privacy Act (20
4 U.S.C. 1232g);

5 (B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

6 (C) Employment records held by a covered entity in its role as employer.

7 (12) "State health plan" means:

8 (a) Medical assistance as defined in ORS 414.025;

9 (b) The Health Care for All Oregon Children program; or

10 (c) Any medical assistance or premium assistance program operated by the Oregon Health Au-
11 thority.

12 (13) "Treatment" includes but is not limited to:

13 (a) The provision, coordination or management of health care; and

14 (b) Consultations and referrals between health care providers.

15 **SECTION 6.** ORS 743B.005, as amended by section 3 of this 2019 Act, is amended to read:

16 743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and
17 743B.128:

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

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

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

30 (a) That is applied uniformly and without regard to any health status related factors to an
31 enrollee or late enrollee;

32 (b) That must expire before any coverage becomes effective under the plan for the enrollee or
33 late enrollee;

34 (c) During which no premium shall be charged to the enrollee or late enrollee; and

35 (d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs
36 concurrently with any eligibility waiting period under the plan.

37 (4) "Bona fide association" means an association that:

38 (a) Has been in active existence for at least five years;

39 (b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

40 (c) Does not condition membership in the association on any factor relating to the health status
41 of an individual or the individual's dependent or employee;

42 (d) Makes health insurance coverage that is offered through the association available to all
43 members of the association regardless of the health status of the member or individuals who are
44 eligible for coverage through the member;

45 (e) Does not make health insurance coverage that is offered through the association available

- 1 other than in connection with a member of the association;
- 2 (f) Has a constitution and bylaws; and
- 3 (g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.
- 4 (5) "Carrier" means any person who provides health benefit plans in this state, including:
- 5 (a) A licensed insurance company;
- 6 (b) A health care service contractor;
- 7 (c) A health maintenance organization;
- 8 (d) An association or group of employers that provides benefits by means of a multiple employer
- 9 welfare arrangement and that:
- 10 (A) Is subject to ORS 750.301 to 750.341; or
- 11 (B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by
- 12 ORS 743B.010 to 743B.013; or
- 13 (e) Any other person or corporation responsible for the payment of benefits or provision of ser-
- 14 vices.
- 15 (6) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms
- 16 of the health benefit plan covering the employee.
- 17 (7) "Eligible employee" means an employee who is eligible for coverage under a group health
- 18 benefit plan.
- 19 (8) "Employee" means any individual employed by an employer.
- 20 (9) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible
- 21 for a group or individual health benefit plan who has enrolled for coverage under the terms of the
- 22 plan.
- 23 (10) "Exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031,
- 24 18032, 18033 and 18041.
- 25 (11) "Exclusion period" means a period during which specified treatments or services are ex-
- 26 cluded from coverage.
- 27 (12) "Financial impairment" means that a carrier is not insolvent and is:
- 28 (a) Considered by the director to be potentially unable to fulfill its contractual obligations; or
- 29 (b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.
- 30 (13)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the
- 31 corresponding highest premium to be charged by a carrier in a geographic area established by the
- 32 director for the carrier's:
- 33 (A) Group health benefit plans offered to small employers; or
- 34 (B) Individual health benefit plans.
- 35 (b) "Geographic average rate" does not include premium differences that are due to differences
- 36 in benefit design, age, tobacco use or family composition.
- 37 (14) "Grandfathered health plan" has the meaning prescribed by rule by the United States Sec-
- 38 retaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) that
- 39 is in effect on January 1, 2017.
- 40 (15) "Group eligibility waiting period" means, with respect to a group health benefit plan, the
- 41 period of employment or membership with the group that a prospective enrollee must complete be-
- 42 fore plan coverage begins.
- 43 (16)(a) "Health benefit plan" means any:
- 44 (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;
- 45 (B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or

1 (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-
 2 ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the
 3 extent that the plan is subject to state regulation.

4 (b) "Health benefit plan" does not include:

5 (A) Coverage for accident only, specific disease or condition only, credit or disability income;

6 (B) Coverage of Medicare services pursuant to contracts with the federal government;

7 (C) Medicare supplement insurance policies;

8 (D) Coverage of TRICARE services pursuant to contracts with the federal government;

9 (E) Benefits delivered through a flexible spending arrangement established pursuant to section
 10 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition
 11 to a group health benefit plan;

12 (F) Separately offered long term care insurance, including, but not limited to, coverage of nurs-
 13 ing home care, home health care and community-based care;

14 (G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity in-
 15 surance;

16 (H) Short term health insurance policies **that are in effect for periods of three months or**
 17 **less, including the term of a renewal of the policy;**

18 (I) Dental only coverage;

19 (J) Vision only coverage;

20 (K) Stop-loss coverage that meets the requirements of ORS 742.065;

21 (L) Coverage issued as a supplement to liability insurance;

22 (M) Insurance arising out of a workers' compensation or similar law;

23 (N) Automobile medical payment insurance or insurance under which benefits are payable with
 24 or without regard to fault and that is statutorily required to be contained in any liability insurance
 25 policy or equivalent self-insurance; or

26 (O) Any employee welfare benefit plan that is exempt from state regulation because of the fed-
 27 eral Employee Retirement Income Security Act of 1974, as amended.

28 **(c) For purposes of this subsection, renewal of a short term health insurance policy in-**
 29 **cludes the issuance of a new short term health insurance policy by an insurer to a**
 30 **policyholder within 60 days after the expiration of a policy previously issued by the insurer**
 31 **to the policyholder.**

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

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

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

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

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

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

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

44 (c) A court issues an order that coverage be provided for a spouse or minor child under an
 45 employee's employer sponsored health benefit plan and request for enrollment is made within 30

1 days after issuance of the court order;

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

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

8 (20) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement
9 as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended,
10 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

11 (21) "Preexisting condition exclusion" means:

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

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

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

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

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

29 (25) "Small employer" means an employer who employed an average of at least one but not more
30 than 50 full-time equivalent employees on business days during the preceding calendar year and who
31 employs at least one full-time equivalent employee on the first day of the plan year, determined in
32 accordance with a methodology prescribed by the Department of Consumer and Business Services
33 by rule.

34 **SECTION 7. Section 2 of this 2019 Act is repealed.**

35 **SECTION 8. The amendments to ORS 743B.005 by section 6 of this 2019 Act and the re-**
36 **peal of section 2 of this 2019 Act by section 7 of this 2019 Act become operative on December**
37 **31, 2021.**

38