

SENATE AMENDMENTS TO SENATE BILL 250

By COMMITTEE ON HEALTH CARE

April 15

1 On page 1 of the printed bill, line 2, after “provisions;” delete the rest of the line and lines 3
2 through 5 and insert “and amending ORS 731.146, 731.804, 743A.168, 743B.011, 743B.125, 743B.126,
3 743B.130 and 743B.800.”.

4 In line 7, delete “ORS 743.405 to” and insert “the Insurance Code.”.

5 Delete lines 8 through 30 and delete pages 2 through 11 and insert:

6 **“SECTION 2. Except as otherwise provided for in the Insurance Code, an individual may**
7 **not, on the basis of actual or perceived race, color, national origin, sex, sexual orientation,**
8 **gender identity, age or disability, be excluded from participation in, be denied the benefits**
9 **of or otherwise be subjected to discrimination under any health benefit plan issued or deliv-**
10 **ered in this state.**

11 **“SECTION 3.** ORS 731.146 is amended to read:

12 “731.146. (1) ‘Transact insurance’ means one or more of the following acts effected by mail or
13 otherwise:

14 “(a) Making or proposing to make an insurance contract.

15 “(b) Taking or receiving any application for insurance.

16 “(c) Receiving or collecting any premium, commission, membership fee, assessment, due or other
17 consideration for any insurance or any part thereof.

18 “(d) Issuing or delivering policies of insurance.

19 “(e) Directly or indirectly acting as an insurance producer for, or otherwise representing or
20 aiding on behalf of another, any person in the solicitation, negotiation, procurement or effectuation
21 of insurance or renewals thereof, the dissemination of information as to coverage or rates, the for-
22 warding of applications, the delivering of policies, the inspection of risks, the fixing of rates, the
23 investigation or adjustment of claims or losses, the transaction of matters subsequent to effectuation
24 of the policy and arising out of it, or in any other manner representing or assisting a person with
25 respect to insurance.

26 “(f) Advertising locally or circularizing therein without regard for the source of such
27 circularization, whenever such advertising or circularization is for the purpose of solicitation of in-
28 surance business.

29 “(g) Doing any other kind of business specifically recognized as constituting the doing of an in-
30 surance business within the meaning of the Insurance Code.

31 “(h) Offering a multistate qualified health plan to individuals or small employers through the
32 program administered by the United States Office of Personnel Management pursuant to 42 U.S.C.
33 18054.

34 “(i) Doing or proposing to do any insurance business in substance equivalent to any of para-
35 graphs (a) to (h) of this subsection in a manner designed to evade the provisions of the Insurance

1 Code.

2 “(2) Subsection (1) of this section does not include, apply to or affect the following:

3 “(a) Making investments within a state by an insurer not admitted or authorized to do business
4 within such state.

5 “(b) Except as provided in ORS 743.015, doing or proposing to do any insurance business arising
6 out of a policy of group life insurance or a policy of blanket health insurance, if the master policy
7 was validly issued to cover a group organized primarily for purposes other than the procurement
8 of insurance and was delivered in and pursuant to the laws of another state in which:

9 “(A) The insurer was authorized to do an insurance business;

10 “(B) The policyholder is domiciled or otherwise has a bona fide situs; and

11 “(C) With respect to a policy of blanket health insurance, the policy was approved by the di-
12 rector of such state.

13 “(c) **Except as provided in ORS 743.015, doing or proposing to do any insurance business**
14 **arising out of a policy of group health insurance, if the master policy was validly issued to**
15 **cover an employer group other than an association, trust or multiple employer welfare ar-**
16 **rangement and was delivered in and pursuant to the laws of another state in which:**

17 “(A) **The insurer was authorized to do an insurance business; and**

18 “(B) **The policyholder is domiciled or otherwise has a bona fide situs.**

19 “[c] (d) Investigating, settling, or litigating claims under policies lawfully written within a
20 state, or liquidating assets and liabilities, all resulting from the insurer’s former authorized oper-
21 ations within such state.

22 “[d] (e) Transactions within a state under a policy subsequent to its issuance if the policy was
23 lawfully solicited, written and delivered outside the state and did not cover a subject of insurance
24 resident, located or to be performed in the state when issued.

25 “[e] (f) The continuation and servicing of life or health insurance policies remaining in force
26 on residents of a state if the insurer has withdrawn from such state and is not transacting new in-
27 surance therein.

28 “(3) If mail is used, an act shall be deemed to take place at the point where the matter trans-
29 mitted by mail is delivered and takes effect.

30 “**SECTION 4.** ORS 731.804 is amended to read:

31 “731.804. (1) Except as otherwise provided in this section, each authorized insurer doing busi-
32 ness in this state shall pay assessments that the Director of the Department of Consumer and
33 Business Services determines are necessary to support the legislatively authorized budget of the
34 Department of Consumer and Business Services with respect to functions of the department under
35 the Insurance Code. The director shall determine the assessments according to one or more per-
36 centage rates established by the director by rule. The director shall specify in the rule when as-
37 sessments shall be made and payments shall be due. The premium-weighted average of the
38 percentage rates may not exceed nine-hundredths of one percent of the gross amount of premiums
39 received by an insurer or the insurer’s insurance producers from and under the insurer’s policies
40 covering direct domestic risks, after deducting the amount of return premiums paid and the amount
41 of dividend payments made to policyholders with respect to such policies. In the case of reciprocal
42 insurers, the amount of savings paid or credited to the accounts of subscribers shall be deducted
43 from the gross amount of premiums. In establishing the percentage rate or rates, the director shall
44 use the most recent premium data approved by the director. In establishing the amounts to be col-
45 lected under this subsection, the director shall take into consideration the expenses of the depart-

1 ment for administering the Insurance Code and the fees collected under subsection (2) of this
2 section. When the director establishes two or more percentage rates:

3 “(a) Each rate shall be based on such expenses of the department ascribed by the director to
4 the line of insurance for which the rate is established.

5 “(b) Each rate shall be applied to the gross amount of premium received by an insurer or its
6 insurance producers for the applicable line of insurance as provided in this subsection.

7 “(2) The director may collect fees for specific services provided by the department under the
8 Insurance Code according to a schedule of fees established by the director by rule. The director may
9 collect such fees in advance. In establishing the schedule for fees, the director shall take into con-
10 sideration the cost of each service for which a fee is imposed.

11 “(3)(a) **Notwithstanding the provisions of ORS 743A.067 (7)(e) and 743A.067 (9), for the**
12 **purpose of mitigating inequity in the health insurance market, the director may assess a fee**
13 **on any insurer that offers a health benefit plan, as defined in ORS 743B.005, that is exempt**
14 **from a provision of ORS chapter 743A or other provision of the Insurance Code that requires**
15 **specified coverage by health benefit plans.**

16 “(b) **Any fees collected under paragraph (a) of this subsection must be the actuarial**
17 **equivalent of costs attributed to the provision and administration of the required coverage**
18 **by an insurer that is not exempt.**

19 “(c) **Nothing in this section limits the authority of the director to enforce the provisions**
20 **of ORS chapter 743A if an insurer unlawfully fails to comply.**

21 “(d) **Notwithstanding ORS 646A.628, fees paid in accordance with paragraph (a) of this**
22 **subsection shall be deposited in the General Fund to become available for general govern-**
23 **mental expenses.**

24 “[3] (4) Establishment and amendment of the schedule of fees under subsection (2) of this sec-
25 tion are subject to prior approval of the Oregon Department of Administrative Services and a report
26 to the Emergency Board prior to adopting the fees and shall be within the budget authorized by the
27 Legislative Assembly as that budget may be modified by the Emergency Board.

28 “[4] (5) The director may not collect an assessment under subsection (1) of this section from
29 any of the following persons:

30 “(a) A fraternal benefit society complying with ORS chapter 748.

31 “(b) Any person or class of persons designated by the director by rule.

32 “[5] (6) The director may not collect an assessment under subsection (1) of this section with
33 respect to premiums received from any of the following policies:

34 “(a) Workers’ compensation insurance policies.

35 “(b) Wet marine and transportation insurance policies.

36 “(c) Any category of policies designated by the director by rule.

37 “**SECTION 5.** ORS 743A.168 is amended to read:

38 “743A.168. (1) As used in this section:

39 “(a) ‘Behavioral health assessment’ means an evaluation by a provider, in person or using tele-
40 medicine, to determine a patient’s need for behavioral health treatment.

41 “(b) ‘Behavioral health crisis’ means a disruption in an individual’s mental or emotional stability
42 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-
43 partment or admission to a hospital to prevent a serious deterioration in the individual’s mental or
44 physical health.

45 “(c) ‘Chemical dependency’ means the addictive relationship with any drug or alcohol charac-

1 terized by a physical or psychological relationship, or both, that interferes on a recurring basis with
2 the individual's social, psychological or physical adjustment to common problems. For purposes of
3 this section, 'chemical dependency' does not include addiction to, or dependency on, tobacco, to-
4 bacco products or foods.

5 "(d) 'Facility' means a corporate or governmental entity or other provider of services for the
6 treatment of chemical dependency or for the treatment of mental or nervous conditions.

7 "(e) 'Group health insurer' means an insurer, a health maintenance organization or a health care
8 service contractor.

9 "(f) 'Program' means a particular type or level of service that is organizationally distinct within
10 a facility.

11 "(g) 'Provider' means:

12 "(A) An individual who has met the credentialing requirement of a group health insurer **or an**
13 **issuer of an individual health benefit plan that is not a grandfathered health plan as defined**
14 **in ORS 743B.005**, is otherwise eligible to receive reimbursement for coverage under the policy and
15 is a behavioral health professional or a medical professional licensed or certified in this state;

16 "(B) A health care facility as defined in ORS 433.060;

17 "(C) A residential facility as defined in ORS 430.010;

18 "(D) A day or partial hospitalization program;

19 "(E) An outpatient service as defined in ORS 430.010; or

20 "(F) A provider organization certified by the Oregon Health Authority under subsection (7) of
21 this section.

22 "(2) A group health insurance policy **or an individual health benefit plan that is not a**
23 **grandfathered health plan** providing coverage for hospital or medical expenses, other than limited
24 benefit coverage, shall provide coverage for expenses arising from the diagnosis of and treatment for
25 chemical dependency, including alcoholism, and for mental or nervous conditions at the same level
26 as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement
27 of expenses arising from treatment for other medical conditions. The following apply to coverage for
28 chemical dependency and for mental or nervous conditions:

29 "(a) The coverage may be made subject to provisions of the policy that apply to other benefits
30 under the policy, including but not limited to provisions relating to deductibles and coinsurance.
31 Deductibles and coinsurance for treatment in health care facilities or residential facilities may not
32 be greater than those under the policy for expenses of hospitalization in the treatment of other
33 medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than
34 those under the policy for expenses of outpatient treatment of other medical conditions.

35 "(b) The coverage may not be made subject to treatment limitations, limits on total payments
36 for treatment, limits on duration of treatment or financial requirements unless similar limitations
37 or requirements are imposed on coverage of other medical conditions. The coverage of eligible ex-
38 penses may be limited to treatment that is medically necessary as determined under the policy for
39 other medical conditions.

40 "(c) The coverage must include:

41 "(A) A behavioral health assessment;

42 "(B) No less than the level of services determined to be medically necessary in a behavioral
43 health assessment of a patient or in a patient's care plan:

44 "(i) To treat the patient's behavioral health condition; and

45 "(ii) For care following a behavioral health crisis, to transition the patient to a lower level of

1 care; and

2 “(C) Coordinated care and case management as defined by the Department of Consumer and
3 Business Services by rule.

4 “(d) A provider is eligible for reimbursement under this section if:

5 “(A) The provider is approved or certified by the Oregon Health Authority;

6 “(B) The provider is accredited for the particular level of care for which reimbursement is being
7 requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities;

8 “(C) The patient is staying overnight at the facility and is involved in a structured program at
9 least eight hours per day, five days per week; or

10 “(D) The provider is providing a covered benefit under the policy.

11 “(e) If specified in the policy, outpatient coverage may include follow-up in-home service or
12 outpatient services. The policy may limit coverage for in-home service to persons who are
13 homebound under the care of a physician.

14 “(f)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to phy-
15 sicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250
16 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed profes-
17 sional counselors and licensed marriage and family therapists, a group health insurer **or issuer of**
18 **an individual health benefit plan** may provide for review for level of treatment of admissions and
19 continued stays for treatment in health facilities, residential facilities, day or partial hospitalization
20 programs and outpatient services by either **staff of a group health insurer or issuer of an indi-**
21 **vidual health benefit plan** [*staff*] or personnel under contract to the group health insurer **or issuer**
22 **of an individual health benefit plan that is not a grandfathered health plan**, or by a utilization
23 review contractor, who shall have the authority to certify for or deny level of payment.

24 “(B) Review shall be made according to criteria made available to providers in advance upon
25 request.

26 “(C) Review shall be performed by or under the direction of a physician licensed under ORS
27 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social
28 worker licensed by the State Board of Licensed Social Workers or a professional counselor or mar-
29 riage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and
30 Therapists, in accordance with standards of the National Committee for Quality Assurance or
31 Medicare review standards of the Centers for Medicare and Medicaid Services.

32 “(D) Review may involve prior approval, concurrent review of the continuation of treatment,
33 post-treatment review or any combination of these. However, if prior approval is required, provision
34 shall be made to allow for payment of urgent or emergency admissions, subject to subsequent re-
35 view. If prior approval is not required, group health insurers **and issuers of individual health**
36 **benefit plans that are not grandfathered health plans** shall permit providers, policyholders or
37 persons acting on their behalf to make advance inquiries regarding the appropriateness of a partic-
38 ular admission to a treatment program. Group health insurers **and issuers of individual health**
39 **benefit plans that are not grandfathered health plans** shall provide a timely response to such
40 inquiries. Noncontracting providers must cooperate with these procedures to the same extent as
41 contracting providers to be eligible for reimbursement.

42 “(g) Health maintenance organizations may limit the receipt of covered services by enrollees to
43 services provided by or upon referral by providers contracting with the health maintenance organ-
44 ization. Health maintenance organizations and health care service contractors may create substan-
45 tive plan benefit and reimbursement differentials at the same level as, and subject to limitations no

1 more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other
2 medical conditions and apply them to contracting and noncontracting providers.

3 “(3) This section does not prohibit a group health insurer **or issuer of an individual health**
4 **benefit plan that is not a grandfathered health plan** from managing the provision of benefits
5 through common methods, including but not limited to selectively contracted panels, health plan
6 benefit differential designs, preadmission screening, prior authorization of services, utilization re-
7 view or other mechanisms designed to limit eligible expenses to those described in subsection (2)(b)
8 of this section.

9 “(4) The Legislative Assembly finds that health care cost containment is necessary and intends
10 to encourage health insurance plans designed to achieve cost containment by ensuring that re-
11 imbursement is limited to appropriate utilization under criteria incorporated into the insurance, ei-
12 ther directly or by reference.

13 “(5) This section does not prevent a group health insurer **or issuer of an individual health**
14 **benefit plan that is not a grandfathered health plan** from contracting with providers of health
15 care services to furnish services to policyholders or certificate holders according to ORS 743B.460
16 or 750.005, subject to the following conditions:

17 “(a) A group health insurer **or issuer of an individual health benefit plan that is not a**
18 **grandfathered health plan** is not required to contract with all providers that are eligible for re-
19 imbursement under this section.

20 “(b) An insurer or health care service contractor shall, subject to subsection (2) of this section,
21 pay benefits toward the covered charges of noncontracting providers of services for the treatment
22 of chemical dependency or mental or nervous conditions. The insured shall, subject to subsection
23 (2) of this section, have the right to use the services of a noncontracting provider of services for the
24 treatment of chemical dependency or mental or nervous conditions, whether or not the services for
25 chemical dependency or mental or nervous conditions are provided by contracting or noncontracting
26 providers.

27 “(6)(a) This section does not require coverage for:

28 “(A) Educational or correctional services or sheltered living provided by a school or halfway
29 house;

30 “(B) A long-term residential mental health program that lasts longer than 45 days;

31 “(C) Psychoanalysis or psychotherapy received as part of an educational or training program,
32 regardless of diagnosis or symptoms that may be present;

33 “(D) A court-ordered sex offender treatment program; or

34 “(E) Support groups.

35 “(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered out-
36 patient services under the terms of the insured’s policy while the insured is living temporarily in a
37 sheltered living situation.

38 “(7) The Oregon Health Authority shall establish a process for the certification of an organiza-
39 tion described in subsection (1)(g)(F) of this section that:

40 “(a) Is not otherwise subject to licensing or certification by the authority; and

41 “(b) Does not contract with the authority, a subcontractor of the authority or a community
42 mental health program.

43 “(8) The Oregon Health Authority shall adopt by rule standards for the certification provided
44 under subsection (7) of this section to ensure that a certified provider organization offers a distinct
45 and specialized program for the treatment of mental or nervous conditions.

1 “(9) The Oregon Health Authority may adopt by rule an application fee or a certification fee,
2 or both, to be imposed on any provider organization that applies for certification under subsection
3 (7) of this section. Any fees collected shall be paid into the Oregon Health Authority Fund estab-
4 lished in ORS 413.101 and shall be used only for carrying out the provisions of subsection (7) of this
5 section.

6 “(10) The intent of the Legislative Assembly in adopting this section is to reserve benefits for
7 different types of care to encourage cost effective care and to ensure continuing access to levels
8 of care most appropriate for the insured’s condition and progress. This section does not prohibit an
9 insurer from requiring a provider organization certified by the Oregon Health Authority under sub-
10 section (7) of this section to meet the insurer’s credentialing requirements as a condition of entering
11 into a contract.

12 “(11) The Director of the Department of Consumer and Business Services and the Oregon Health
13 Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section
14 that are considered necessary for the proper administration of this section.

15 “**SECTION 6.** ORS 743B.011 is amended to read:

16 “743B.011. (1) **Except as provided in subsection (2) of this section,** every health benefit plan
17 shall be subject to the provisions of ORS 743B.010 to 743B.013, if the plan provides health benefits
18 covering one or more employees of a small employer and if any one of the following conditions is
19 met:

20 “(a) Any portion of the premium or benefits is paid by a small employer or any employee is re-
21 imbursement, whether through wage adjustments or otherwise, by a small employer for any portion of
22 the health benefit plan premium [*unless the reimbursement is made through a qualified small employer*
23 *health reimbursement arrangement, as defined in section 9831 of the Internal Revenue Code*]; or

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

27 “**(2) Subsection (1) of this section does not apply to:**

28 “**(a) An individual health benefit plan for which a portion of the premium is reimbursed**
29 **through a qualified small employer health reimbursement arrangement as defined in section**
30 **9831 of the Internal Revenue Code; or**

31 “**(b) An individual health benefit plan that is considered to be integrated with a health**
32 **reimbursement arrangement or other account-based group health plan authorized by federal**
33 **law.**

34 “[2] **(3)** Except as otherwise provided by ORS 743B.010 to 743B.013 or other law, no health
35 benefit plan offered to a small employer shall:

36 “(a) Inhibit a carrier from contracting with providers or groups of providers with respect to
37 health care services or benefits; or

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

40 “[3](a) **(4)(a)** A carrier may provide different health benefit plans to different categories of
41 employees of a small employer when the employer has chosen to establish different categories of
42 employees in a manner that does not relate to the actual or expected health status of such em-
43 ployees or their dependents. The categories must be based on bona fide employment-based classi-
44 fications that are consistent with the employer’s usual business practice.

45 “(b) Except as provided in ORS 743B.012 (7), a carrier that offers coverage to a small employer

1 shall offer coverage to all eligible employees of the small employer.

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

4 “[4] (5) An insurer may not deny, delay or terminate participation of an individual in a group
5 health benefit plan or exclude coverage otherwise provided to an individual under a group health
6 benefit plan based on a preexisting condition of the individual.

7 “**SECTION 7.** ORS 743B.125 is amended to read:

8 “743B.125. (1) With respect to coverage under an individual health benefit plan **other than a**
9 **grandfathered health plan**, a carrier may not impose **a preexisting condition exclusion or an**
10 **individual coverage waiting period.**

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

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

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

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

19 “(B) The exclusion expires no later than six months after the individual’s effective date of cov-
20 erage.

21 “(c) **May not impose a waiting period.**

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

24 “(4)(a) **A carrier shall issue any individual health benefit plan offered by the carrier,**
25 **other than a grandfathered health plan, to any individual who applies for the health benefit**
26 **plan, if:**

27 “(A) **The individual resides in the geographic area where the plan is offered;**

28 “(B) **The individual agrees to make the required premium payments; and**

29 “(C) **Issuance of the health benefit plan is not otherwise prohibited by law.**

30 “(b) **The Department of Consumer and Business Services may allow a carrier to cap the**
31 **number of individuals enrolled in an individual health benefit plan offered by the carrier if**
32 **the department finds that issuing the health benefit plan to more individuals than are cur-**
33 **rently enrolled in the plan would have a material adverse effect upon the carrier’s ability to**
34 **fulfill the carrier’s contractual obligations or result in the financial impairment of the car-**
35 **rier.**

36 “(c) **Except as otherwise provided in this section and ORS 743.022, a carrier offering an**
37 **individual health benefit plan may not impose different terms or conditions on the coverage**
38 **provided or the premium charged based on the actual or expected health status of an**
39 **enrollee or prospective enrollee.**

40 “[4] (5) A carrier shall renew an individual health benefit plan, including a health benefit plan
41 issued through a bona fide association, unless:

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

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

45 “(c) The carrier discontinues both offering and renewing all of the carrier’s individual health

1 benefit plans in this state or in a specified service area within this state. In order to discontinue the
2 plans under this paragraph, the carrier:

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

5 “(B) May not cancel coverage under the plans for 180 days after the date of the notice required
6 under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a
7 specified service area, except that:

8 “(i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if
9 the cancellation is for a specified service area in the circumstances described in subparagraph (C)
10 of this paragraph; and

11 “(ii) The Director of the Department of Consumer and Business Services may specify a cancel-
12 lation date other than the cancellation date specified in this subparagraph if the carrier is subject
13 to a delinquency proceeding, as defined in ORS 734.014; and

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

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

22 “(A) Shall give notice of the decision to the department and to all policyholders covered by the
23 plan;

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

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

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

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

35 “(g) With respect to plans that are being discontinued under paragraph (e) or (f) of this sub-
36 section, the carrier shall:

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

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

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

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

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

1 “(B) Impair the carrier’s ability to meet the carrier’s contractual obligations.

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

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

9 “[5] (6) A carrier may modify an individual health benefit plan at the time of coverage renewal.
10 The modification is not a discontinuation of the plan under subsection [(4)(c)] (5)(c), (e) and (f) of
11 this section.

12 “[6] (7) Notwithstanding any other provision of this section, and subject to the provisions of
13 ORS 743B.310 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder
14 or a representative of the policyholder:

15 “(a) Performs an act, practice or omission that constitutes fraud; or
16 “(b) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the
17 policy.

18 “[7] (8) A carrier that continues to offer coverage in the individual market in this state is not
19 required to offer coverage in all of the carrier’s individual health benefit plans. However, if a carrier
20 elects to continue a plan that is closed to new individual policyholders instead of offering alterna-
21 tive coverage in the carrier’s other individual health benefit plans, the coverage for all existing
22 policyholders in the closed plan is renewable in accordance with subsection [(4)] (5) of this section.

23 “[8] (9) An individual health benefit plan may not impose annual or lifetime limits on the dollar
24 amount of essential health benefits.

25 “[9] (10) A grandfathered health plan may not impose lifetime limits on the dollar amount of
26 essential health benefits.

27 “[10] (11) This section does not require a carrier to actively market, offer, issue or accept ap-
28 plications for:

29 “(a) A bona fide association health benefit plan from individuals who are not members of the
30 bona fide association; or
31 “(b) A grandfathered health plan from individuals who are not eligible for coverage under the
32 plan.

33 “**SECTION 8.** ORS 743B.126 is amended to read:
34 “743B.126. (1) Each carrier shall actively market all individual health benefit plans sold by the
35 carrier that are not grandfathered health plans.

36 “(2) Except as provided in subsection (3) of this section, no carrier or insurance producer shall,
37 directly or indirectly, discourage an individual from filing an application for coverage because of the
38 health status, claims experience, occupation or geographic location of the individual.

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

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

44 “(5) The Director of the Department of Consumer and Business Services may establish by rule
45 additional standards to provide for the fair marketing and broad availability of individual health

1 benefit plans.

2 “(6) A carrier that elects to discontinue offering all of its individual health benefit plans under
3 ORS 743B.125 [(4)(c)] (5)(c) or to discontinue both offering and renewing all such plans is prohibited
4 from offering and renewing health benefit plans in the individual market in this state for a period
5 of five years from the date of notice to the director pursuant to ORS 743B.125 [(4)(c)] (5)(c) or, if
6 such notice is not provided, from the date on which the director provides notice to the carrier that
7 the director has determined that the carrier has effectively discontinued offering individual health
8 benefit plans in this state. This subsection does not apply with respect to a health benefit plan dis-
9 continued in a specified service area by a carrier that covers services provided only by a particular
10 organization of health care providers or only by health care providers who are under contract with
11 the carrier.

12 “(7) The Department of Consumer and Business Services may, in accordance with ORS 743B.129,
13 shorten the period of prohibition described in subsection (6) of this section if necessary to ensure,
14 in all geographic areas of this state, that:

15 “(a) A competitive health insurance market exists;

16 “(b) Consumers have a reasonable number of health insurance options available to them; and

17 “(c) Consumers who purchase insurance are protected.

18 “**SECTION 9.** ORS 743B.130 is amended to read:

19 “743B.130. (1) In each individual or small group market, in which a carrier offers a health ben-
20 efit plan through or outside of the health insurance exchange described in ORS 741.310, the carrier
21 must offer to residents of this state [a] bronze and [a] silver [*plan*] **plans** certified by the Department
22 of Consumer and Business Services as qualified health plans and meeting the requirements of sub-
23 section (2) of this section.

24 “(2) The department shall prescribe by rule, in accordance with federal requirements, the form,
25 level of coverage and benefit design for the bronze and silver plans that must be offered under
26 subsection (1) of this section.

27 “(3) As used in this section, ‘health benefit plan’ has the meaning given that term in ORS
28 743B.005.

29 “**SECTION 10.** ORS 743B.800 is amended to read:

30 “743B.800. (1) As used in this section, ‘health benefit plan’ means a health benefit plan, as de-
31 fined in ORS 743B.005, that is offered in the individual or small group market.

32 “(2) The Department of Consumer and Business Services may establish by rule a procedure for
33 adjusting risk between insurers. If a procedure is established[,]:

34 “(a) The procedure may include:

35 “[*a*] (A) An assessment imposed on an insurer if the actuarial risk of the enrollees in the
36 insurer’s health benefit plans is less than the average actuarial risk of all enrollees in all health
37 benefit plans in this state; and

38 “[*b*] (B) Payments to insurers if the actuarial risk of the enrollees in the insurer’s health
39 benefit plans is greater than the average actuarial risk of all enrollees in all health benefit plans
40 in this state.

41 “[*3*] (b) [*A procedure established under this section*] **The methodology for adjusting risk be-**
42 **tween insurers** must be consistent with 42 U.S.C. 18063 and regulations adopted by the Secretary
43 of the United States Department of Health and Human Services to carry out 42 U.S.C. 18063 that
44 are in effect on January 1, [2017] **2019**.

45 “**SECTION 11. Section 2 of this 2019 Act and the amendments to ORS 731.146, 731.804,**

1 **743A.168, 743B.011, 743B.125, 743B.126, 743B.130 and 743B.800 by sections 3 to 10 of this 2019**
2 **Act apply to health insurance policies issued or renewed on or after the effective date of this**
3 **2019 Act.”**

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