

SB 250-2
(LC 521)
4/3/19 (LHF/ps)

Requested by SENATE COMMITTEE ON HEALTH CARE (at the request of the Department of Consumer and Business Services)

**PROPOSED AMENDMENTS TO
SENATE BILL 250**

1 On page 1 of the printed bill, line 2, after “provisions;” delete the rest
2 of the line and lines 3 through 5 and insert “and amending ORS 731.146,
3 731.804, 743A.168, 743B.011, 743B.125, 743B.126, 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**
7 **Code, an individual may not, on the basis of actual or perceived race,**
8 **color, national origin, sex, sexual orientation, gender identity, age or**
9 **disability, be excluded from participation in, be denied the benefits of**
10 **or otherwise be subjected to discrimination under any health benefit**
11 **plan issued or delivered in this state.**

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

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

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

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

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

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

20 “(e) Directly or indirectly acting as an insurance producer for, or other-
21 wise representing or aiding on behalf of another, any person in the sollicita-

1 tion, negotiation, procurement or effectuation of insurance or renewals
2 thereof, the dissemination of information as to coverage or rates, the for-
3 warding of applications, the delivering of policies, the inspection of risks, the
4 fixing of rates, the investigation or adjustment of claims or losses, the
5 transaction of matters subsequent to effectuation of the policy and arising
6 out of it, or in any other manner representing or assisting a person with
7 respect to insurance.

8 “(f) Advertising locally or circularizing therein without regard for the
9 source of such circularization, whenever such advertising or circularization
10 is for the purpose of solicitation of insurance business.

11 “(g) Doing any other kind of business specifically recognized as consti-
12 tuting the doing of an insurance business within the meaning of the Insur-
13 ance Code.

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

17 “(i) Doing or proposing to do any insurance business in substance equiv-
18 alent to any of paragraphs (a) to (h) of this subsection in a manner designed
19 to evade the provisions of the Insurance Code.

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

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

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

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

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

2 “(C) With respect to a policy of blanket health insurance, the policy was
3 approved by the director of such state.

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

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

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

13 “[c] (d) Investigating, settling, or litigating claims under policies law-
14 fully written within a state, or liquidating assets and liabilities, all resulting
15 from the insurer’s former authorized operations within such state.

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

20 “[e] (f) The continuation and servicing of life or health insurance poli-
21 cies remaining in force on residents of a state if the insurer has withdrawn
22 from such state and is not transacting new insurance therein.

23 “(3) If mail is used, an act shall be deemed to take place at the point
24 where the matter transmitted by mail is delivered and takes effect.

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

26 “731.804. (1) Except as otherwise provided in this section, each authorized
27 insurer doing business in this state shall pay assessments that the Director
28 of the Department of Consumer and Business Services determines are neces-
29 sary to support the legislatively authorized budget of the Department of
30 Consumer and Business Services with respect to functions of the department

1 under the Insurance Code. The director shall determine the assessments ac-
2 cording to one or more percentage rates established by the director by rule.
3 The director shall specify in the rule when assessments shall be made and
4 payments shall be due. The premium-weighted average of the percentage
5 rates may not exceed nine-hundredths of one percent of the gross amount of
6 premiums received by an insurer or the insurer's insurance producers from
7 and under the insurer's policies covering direct domestic risks, after deduct-
8 ing the amount of return premiums paid and the amount of dividend pay-
9 ments made to policyholders with respect to such policies. In the case of
10 reciprocal insurers, the amount of savings paid or credited to the accounts
11 of subscribers shall be deducted from the gross amount of premiums. In es-
12 tablishing the percentage rate or rates, the director shall use the most recent
13 premium data approved by the director. In establishing the amounts to be
14 collected under this subsection, the director shall take into consideration the
15 expenses of the department for administering the Insurance Code and the
16 fees collected under subsection (2) of this section. When the director estab-
17 lishes two or more percentage rates:

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

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

23 “(2) The director may collect fees for specific services provided by the
24 department under the Insurance Code according to a schedule of fees estab-
25 lished by the director by rule. The director may collect such fees in advance.
26 In establishing the schedule for fees, the director shall take into consider-
27 ation the cost of each service for which a fee is imposed.

28 **“(3)(a) Notwithstanding the provisions of ORS 743A.067 (7)(e) and**
29 **743A.067 (9), for the purpose of mitigating inequity in the health in-**
30 **surance market, the director may assess a fee on any insurer that of-**

1 **fers a health benefit plan, as defined in ORS 743B.005, that is exempt**
2 **from a provision of ORS chapter 743A or other provision of the In-**
3 **surance Code that requires specified coverage by health benefit plans.**

4 **“(b) Any fees collected under paragraph (a) of this subsection must**
5 **be the actuarial equivalent of costs attributed to the provision and**
6 **administration of the required coverage by an insurer that is not ex-**
7 **empt.**

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

11 **“(d) Notwithstanding ORS 646A.628, fees paid in accordance with**
12 **paragraph (a) of this subsection shall be deposited in the General Fund**
13 **to become available for general governmental expenses.**

14 **“[(3)] (4) Establishment and amendment of the schedule of fees under**
15 **subsection (2) of this section are subject to prior approval of the Oregon**
16 **Department of Administrative Services and a report to the Emergency Board**
17 **prior to adopting the fees and shall be within the budget authorized by the**
18 **Legislative Assembly as that budget may be modified by the Emergency**
19 **Board.**

20 **“[(4)] (5) The director may not collect an assessment under subsection (1)**
21 **of this section from any of the following persons:**

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

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

24 **“[(5)] (6) The director may not collect an assessment under subsection (1)**
25 **of this section with respect to premiums received from any of the following**
26 **policies:**

27 **“(a) Workers’ compensation insurance policies.**

28 **“(b) Wet marine and transportation insurance policies.**

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

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

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

2 “(a) ‘Behavioral health assessment’ means an evaluation by a provider, in
3 person or using telemedicine, to determine a patient’s need for behavioral
4 health treatment.

5 “(b) ‘Behavioral health crisis’ means a disruption in an individual’s men-
6 tal or emotional stability or functioning resulting in an urgent need for im-
7 mediate outpatient treatment in an emergency department or admission to
8 a hospital to prevent a serious deterioration in the individual’s mental or
9 physical health.

10 “(c) ‘Chemical dependency’ means the addictive relationship with any
11 drug or alcohol characterized by a physical or psychological relationship, or
12 both, that interferes on a recurring basis with the individual’s social, psy-
13 chological or physical adjustment to common problems. For purposes of this
14 section, ‘chemical dependency’ does not include addiction to, or dependency
15 on, tobacco, tobacco products or foods.

16 “(d) ‘Facility’ means a corporate or governmental entity or other provider
17 of services for the treatment of chemical dependency or for the treatment of
18 mental or nervous conditions.

19 “(e) ‘Group health insurer’ means an insurer, a health maintenance or-
20 ganization or a health care service contractor.

21 “(f) ‘Program’ means a particular type or level of service that is organ-
22 izationally distinct within a facility.

23 “(g) ‘Provider’ means:

24 “(A) An individual who has met the credentialing requirement of a group
25 health insurer **or an issuer of an individual health benefit plan that is**
26 **not a grandfathered health plan as defined in ORS 743B.005**, is otherwise
27 eligible to receive reimbursement for coverage under the policy and is a be-
28 havioral health professional or a medical professional licensed or certified
29 in this state;

30 “(B) A health care facility as defined in ORS 433.060;

1 “(C) A residential facility as defined in ORS 430.010;
2 “(D) A day or partial hospitalization program;
3 “(E) An outpatient service as defined in ORS 430.010; or
4 “(F) A provider organization certified by the Oregon Health Authority
5 under subsection (7) of this section.

6 “(2) A group health insurance policy **or an individual health benefit**
7 **plan that is not a grandfathered health plan** providing coverage for hos-
8 pital or medical expenses, other than limited benefit coverage, shall provide
9 coverage for expenses arising from the diagnosis of and treatment for chem-
10 ical dependency, including alcoholism, and for mental or nervous conditions
11 at the same level as, and subject to limitations no more restrictive than,
12 those imposed on coverage or reimbursement of expenses arising from treat-
13 ment for other medical conditions. The following apply to coverage for
14 chemical dependency and for mental or nervous conditions:

15 “(a) The coverage may be made subject to provisions of the policy that
16 apply to other benefits under the policy, including but not limited to pro-
17 visions relating to deductibles and coinsurance. Deductibles and coinsurance
18 for treatment in health care facilities or residential facilities may not be
19 greater than those under the policy for expenses of hospitalization in the
20 treatment of other medical conditions. Deductibles and coinsurance for out-
21 patient treatment may not be greater than those under the policy for ex-
22 penses of outpatient treatment of other medical conditions.

23 “(b) The coverage may not be made subject to treatment limitations, lim-
24 its on total payments for treatment, limits on duration of treatment or fi-
25 nancial requirements unless similar limitations or requirements are imposed
26 on coverage of other medical conditions. The coverage of eligible expenses
27 may be limited to treatment that is medically necessary as determined under
28 the policy for other medical conditions.

29 “(c) The coverage must include:

30 “(A) A behavioral health assessment;

1 “(B) No less than the level of services determined to be medically neces-
2 sary in a behavioral health assessment of a patient or in a patient’s care
3 plan:

4 “(i) To treat the patient’s behavioral health condition; and

5 “(ii) For care following a behavioral health crisis, to transition the pa-
6 tient to a lower level of care; and

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

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

10 “(A) The provider is approved or certified by the Oregon Health Author-
11 ity;

12 “(B) The provider is accredited for the particular level of care for which
13 reimbursement is being requested by the Joint Commission or the Commis-
14 sion on Accreditation of Rehabilitation Facilities;

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

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

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

21 “(f)(A) Subject to the patient or client confidentiality provisions of ORS
22 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS
23 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed
24 clinical social workers and ORS 40.262 relating to licensed professional
25 counselors and licensed marriage and family therapists, a group health
26 insurer **or issuer of an individual health benefit plan** may provide for
27 review for level of treatment of admissions and continued stays for treatment
28 in health facilities, residential facilities, day or partial hospitalization pro-
29 grams and outpatient services by either **staff of a group health insurer or**
30 **issuer of an individual health benefit plan** [*staff*] or personnel under

1 contract to the group health insurer **or issuer of an individual health**
2 **benefit plan that is not a grandfathered health plan**, or by a utilization
3 review contractor, who shall have the authority to certify for or deny level
4 of payment.

5 “(B) Review shall be made according to criteria made available to pro-
6 viders in advance upon request.

7 “(C) Review shall be performed by or under the direction of a physician
8 licensed under ORS 677.100 to 677.228, a psychologist licensed by the Oregon
9 Board of Psychology, a clinical social worker licensed by the State Board
10 of Licensed Social Workers or a professional counselor or marriage and
11 family therapist licensed by the Oregon Board of Licensed Professional
12 Counselors and Therapists, in accordance with standards of the National
13 Committee for Quality Assurance or Medicare review standards of the Cen-
14 ters for Medicare and Medicaid Services.

15 “(D) Review may involve prior approval, concurrent review of the con-
16 tinuation of treatment, post-treatment review or any combination of these.
17 However, if prior approval is required, provision shall be made to allow for
18 payment of urgent or emergency admissions, subject to subsequent review.
19 If prior approval is not required, group health insurers **and issuers of in-**
20 **dividual health benefit plans that are not grandfathered health plans**
21 shall permit providers, policyholders or persons acting on their behalf to
22 make advance inquiries regarding the appropriateness of a particular admis-
23 sion to a treatment program. Group health insurers **and issuers of indi-**
24 **vidual health benefit plans that are not grandfathered health plans**
25 shall provide a timely response to such inquiries. Noncontracting providers
26 must cooperate with these procedures to the same extent as contracting
27 providers to be eligible for reimbursement.

28 “(g) Health maintenance organizations may limit the receipt of covered
29 services by enrollees to services provided by or upon referral by providers
30 contracting with the health maintenance organization. Health maintenance

1 organizations and health care service contractors may create substantive
2 plan benefit and reimbursement differentials at the same level as, and subject
3 to limitations no more restrictive than, those imposed on coverage or re-
4 imbursement of expenses arising out of other medical conditions and apply
5 them to contracting and noncontracting providers.

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

13 “(4) The Legislative Assembly finds that health care cost containment is
14 necessary and intends to encourage health insurance plans designed to
15 achieve cost containment by ensuring that reimbursement is limited to ap-
16 propriate utilization under criteria incorporated into the insurance, either
17 directly or by reference.

18 “(5) This section does not prevent a group health insurer **or issuer of**
19 **an individual health benefit plan that is not a grandfathered health**
20 **plan** from contracting with providers of health care services to furnish ser-
21 vices to policyholders or certificate holders according to ORS 743B.460 or
22 750.005, subject to the following conditions:

23 “(a) A group health insurer **or issuer of an individual health benefit**
24 **plan that is not a grandfathered health plan** is not required to contract
25 with all providers that are eligible for reimbursement under this section.

26 “(b) An insurer or health care service contractor shall, subject to sub-
27 section (2) of this section, pay benefits toward the covered charges of non-
28 contracting providers of services for the treatment of chemical dependency
29 or mental or nervous conditions. The insured shall, subject to subsection (2)
30 of this section, have the right to use the services of a noncontracting pro-

1 vider of services for the treatment of chemical dependency or mental or
2 nervous conditions, whether or not the services for chemical dependency or
3 mental or nervous conditions are provided by contracting or noncontracting
4 providers.

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

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

8 “(B) A long-term residential mental health program that lasts longer than
9 45 days;

10 “(C) Psychoanalysis or psychotherapy received as part of an educational
11 or training program, regardless of diagnosis or symptoms that may be pres-
12 ent;

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

14 “(E) Support groups.

15 “(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may
16 receive covered outpatient services under the terms of the insured’s policy
17 while the insured is living temporarily in a sheltered living situation.

18 “(7) The Oregon Health Authority shall establish a process for the certi-
19 fication of an organization described in subsection (1)(g)(F) of this section
20 that:

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

23 “(b) Does not contract with the authority, a subcontractor of the author-
24 ity or a community mental health program.

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

29 “(9) The Oregon Health Authority may adopt by rule an application fee
30 or a certification fee, or both, to be imposed on any provider organization

1 that applies for certification under subsection (7) of this section. Any fees
2 collected shall be paid into the Oregon Health Authority Fund established
3 in ORS 413.101 and shall be used only for carrying out the provisions of
4 subsection (7) of this section.

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

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

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

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

22 “(a) Any portion of the premium or benefits is paid by a small employer
23 or any employee is reimbursed, whether through wage adjustments or other-
24 wise, by a small employer for any portion of the health benefit plan premium
25 [*unless the reimbursement is made through a qualified small employer health*
26 *reimbursement arrangement, as defined in section 9831 of the Internal Revenue*
27 *Code*]; or

28 “(b) The health benefit plan is treated by the employer or any of the em-
29 ployees as part of a plan or program for the purposes of section 106, section
30 125 or section 162 of the Internal Revenue Code of 1986, as amended.

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

2 “(a) An individual health benefit plan for which a portion of the
3 premium is reimbursed through a qualified small employer health re-
4 imbursement arrangement as defined in section 9831 of the Internal
5 Revenue Code; or

6 “(b) An individual health benefit plan that is considered to be inte-
7 grated with a health reimbursement arrangement or other account-
8 based group health plan authorized by federal law.

9 “[(2)] (3) Except as otherwise provided by ORS 743B.010 to 743B.013 or
10 other law, no health benefit plan offered to a small employer shall:

11 “(a) Inhibit a carrier from contracting with providers or groups of pro-
12 viders with respect to health care services or benefits; or

13 “(b) Impose any restriction on the ability of a carrier to negotiate with
14 providers regarding the level or method of reimbursing care or services pro-
15 vided under health benefit plans.

16 “[(3)(a)] (4)(a) A carrier may provide different health benefit plans to
17 different categories of employees of a small employer when the employer has
18 chosen to establish different categories of employees in a manner that does
19 not relate to the actual or expected health status of such employees or their
20 dependents. The categories must be based on bona fide employment-based
21 classifications that are consistent with the employer’s usual business prac-
22 tice.

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

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

29 “[(4)] (5) An insurer may not deny, delay or terminate participation of an
30 individual in a group health benefit plan or exclude coverage otherwise

1 provided to an individual under a group health benefit plan based on a pre-
2 existing condition of the individual.

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

4 “743B.125. (1) With respect to coverage under an individual health benefit
5 plan **other than a grandfathered health plan**, a carrier may not impose
6 **a preexisting condition exclusion or** an individual coverage waiting pe-
7 riod.

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

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

13 “(b) May not impose a preexisting condition exclusion unless the exclu-
14 sion complies with the following requirements:

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

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

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

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

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

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

29 **“(B) The individual agrees to make the required premium pay-**
30 **ments; and**

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

3 **“(b) The Department of Consumer and Business Services may allow**
4 **a carrier to cap the number of individuals enrolled in an individual**
5 **health benefit plan offered by the carrier if the department finds that**
6 **issuing the health benefit plan to more individuals than are currently**
7 **enrolled in the plan would have a material adverse effect upon the**
8 **carrier’s ability to fulfill the carrier’s contractual obligations or result**
9 **in the financial impairment of the carrier.**

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

15 **“[(4)] (5) A carrier shall renew an individual health benefit plan, includ-**
16 **ing a health benefit plan issued through a bona fide association, unless:**

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

18 **“(b) The policyholder or a representative of the policyholder engages in**
19 **fraud or makes an intentional misrepresentation of a material fact as pro-**
20 **hibited by the terms of the policy.**

21 **“(c) The carrier discontinues both offering and renewing all of the**
22 **carrier’s individual health benefit plans in this state or in a specified service**
23 **area within this state. In order to discontinue the plans under this para-**
24 **graph, the carrier:**

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

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

30 **“(i) The carrier shall cancel coverage in accordance with subparagraph**

1 (C) of this paragraph if the cancellation is for a specified service area in the
2 circumstances described in subparagraph (C) of this paragraph; and

3 “(ii) The Director of the Department of Consumer and Business Services
4 may specify a cancellation date other than the cancellation date specified in
5 this subparagraph if the carrier is subject to a delinquency proceeding, as
6 defined in ORS 734.014; and

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

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

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

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

21 “(C) Shall offer in writing to each policyholder covered by the plan, all
22 other individual health benefit plans that the carrier offers in the specified
23 service area. The carrier shall offer the plans at least 90 days prior to dis-
24 continuation.

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

29 “(f) The carrier discontinues both offering and renewing a grandfathered
30 health plan for all individuals in this state or in a specified service area

1 within this state, other than a plan discontinued under paragraph (d) of this
2 subsection.

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

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

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

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

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

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

16 “(B) Impair the carrier’s ability to meet the carrier’s contractual obli-
17 gations.

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

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

27 “[5] (6) A carrier may modify an individual health benefit plan at the
28 time of coverage renewal. The modification is not a discontinuation of the
29 plan under subsection [(4)(c)] (5)(c), (e) and (f) of this section.

30 “[6] (7) Notwithstanding any other provision of this section, and subject

1 to the provisions of ORS 743B.310 (2) and (4), a carrier may rescind an in-
2 dividual health benefit plan if the policyholder or a representative of the
3 policyholder:

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

5 “(b) Makes an intentional misrepresentation of a material fact as pro-
6 hibited by the terms of the policy.

7 “[7] (8) A carrier that continues to offer coverage in the individual
8 market in this state is not required to offer coverage in all of the carrier’s
9 individual health benefit plans. However, if a carrier elects to continue a
10 plan that is closed to new individual policyholders instead of offering alter-
11 native coverage in the carrier’s other individual health benefit plans, the
12 coverage for all existing policyholders in the closed plan is renewable in
13 accordance with subsection [(4)] (5) of this section.

14 “[8] (9) An individual health benefit plan may not impose annual or
15 lifetime limits on the dollar amount of essential health benefits.

16 “[9] (10) A grandfathered health plan may not impose lifetime limits on
17 the dollar amount of essential health benefits.

18 “[10] (11) This section does not require a carrier to actively market, of-
19 fer, issue or accept applications for:

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

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

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

25 “743B.126. (1) Each carrier shall actively market all individual health
26 benefit plans sold by the carrier that are not grandfathered health plans.

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

1 “(3) Subsection (2) of this section does not apply with respect to infor-
2 mation provided by a carrier to an individual regarding the established ge-
3 ographic service area or a restricted network provision of a carrier.

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

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

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

21 “(7) The Department of Consumer and Business Services may, in accord-
22 ance with ORS 743B.129, shorten the period of prohibition described in sub-
23 section (6) of this section if necessary to ensure, in all geographic areas of
24 this state, that:

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

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

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

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

30 “743B.130. (1) In each individual or small group market, in which a car-

1 rier offers a health benefit plan through or outside of the health insurance
2 exchange described in ORS 741.310, the carrier must offer to residents of this
3 state [a] bronze and [a] silver [plan] **plans** certified by the Department of
4 Consumer and Business Services as qualified health plans and meeting the
5 requirements of subsection (2) of this section.

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

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

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

12 “743B.800. (1) As used in this section, ‘health benefit plan’ means a health
13 benefit plan, as defined in ORS 743B.005, that is offered in the individual or
14 small group market.

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

18 **“(a)** The procedure may include:

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

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

25 “[3] **(b)** [A procedure established under this section] **The methodology**
26 **for adjusting risk between insurers** must be consistent with 42 U.S.C.
27 18063 and regulations adopted by the Secretary of the United States Depart-
28 ment of Health and Human Services to carry out 42 U.S.C. 18063 that are in
29 effect on January 1, [2017] **2019**.

30 **“SECTION 11. Section 2 of this 2019 Act and the amendments to**

1 **ORS 731.146, 731.804, 743A.168, 743B.011, 743B.125, 743B.126, 743B.130 and**
2 **743B.800 by sections 3 to 10 of this 2019 Act apply to health insurance**
3 **policies issued or renewed on or after the effective date of this 2019**
4 **Act.”.**

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